DOCUMENT RESUME

ED 184 661 PS 011 205

AUTHOR Callard, Esther Dean, Comp.; Morin, Patricia E., Comp.
TITLE PACT: Parents And Children Together. An Alternative to Foster Care.
INSTITUTION Wayne State Univ., Detroit, Mich.
PUB DATE 79
NOTE 173p.

EDRS PRICE MF01/PC07 Plus Postage.
DESCRIPTORS Crisis Intervention; *Family (Sociological Unit); Family Problems; *Foster Children; *Home Programs; Innovation; *Low Income; Models; Parent Education; Program Content; Program Evaluation; *Risk; *Social Development; Social Services

ABSTRACT

This report describes the Detroit, Michigan, Parents and Children Together (PACT) project which provides an intensive, home based intervention service to low-income families who have, or are at risk of having, a child placed in foster care. Part I of this report describes how staff members are selected and trained, how goals are formulated for each family, and how objectives are met. Part II consists of two reports. Given first are descriptive statistics on the client population, delivery of service, and status outcomes after two months of service. In addition, a non-experimental research project involving 51 families studied over a four-month period is reported. In Part III conclusions and implications are discussed regarding changes in the PACT program and services to families in a broad social context. In this report an attempt is made to describe PACT's philosophy and operation in sufficient depth and detail so that it can serve as a model for others who are seeking an "alternative to foster care." Editors emphasize that the project model should not be considered a product: it is a model of a flexible, responsive process based on specially trained personnel, close interpersonal relationships between caseworker and client, programing responsive to client needs, and systematic case monitoring. Project materials and forms are included in 16 appendices. (Author/RH)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED184661

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

PACT

Parents And Children Together

An Alternative to Foster Care

Compiled and Edited by
ESTHER DEAN CALLARD
and
PATRICIA E. MORIN

PS 011205

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Esther Dean Callard
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Department of Family and Consumer Resources
Wayne State University, Detroit 1979

Copyright © 1979 by Department of Family and Consumer Resources, Parents and Children Together, Wayne State University, Detroit, Michigan 48202.
All rights reserved. No part of this book may be reproduced in any form by any electronic or mechanical means, including information storage and retrieval systems, without permission in writing from the publisher, except by a reviewer, who may quote brief passages in a review.
Publication was made possible by a grant from Wayne County, Michigan Department of Social Services.

Library of Congress Cataloging in Publication Data

Main entry under title:

PACT: parents and children together.

Bibliography: p.
1. Family social work—Michigan—Wayne Co.—Case studies. 2. Social work with children—Michigan—Wayne Co.—Case studies. 3. Parenting—Michigan—Wayne Co.—Case studies. 4. Child development—Michigan—Wayne Co.—Case studies. I. Callard, Esther Dean, 1917– II. Morin, Patricia E., 1932–
HV699.P13 362.8'2'0977433 79-15980

Names of the clients have been changed to protect the privacy of the individuals involved.

Contents

Preface 5

Introduction / Esther Dean Callard 7

PART I
PACT
The Service Model / Patricia E. Morin 11

Introduction 13
Training and Preparation of Staff 14
Personnel 14
Selection and Training of Counselors 15
Academic Training 17
The Counselor's Role 19
The Teamwork Approach 20
Control of Caseload 22
Time Budgeting 23
Staff Morale 24
Systematic Review and Assessment 26
The Service Process 26
Referral and Eligibility of Clients 27
The Intake Process 28
Development of a Treatment Plan 29
The Counselor-Client Relationship 29 / A Relevant Knowledge Base 31 / Organized Planning 33 / Availability of Resources 34 / Beneficial Relationship to Other Services and Agencies 36
Combined Individualized and Theoretical Approach 39
The Counseling Approach 39 / Modeling and Demonstration 39 / Reeducation 40
Persistence in Difficult Cases 43
Case Continuation 46
Case Termination 46
Criteria for Termination 46 / Termination Procedure 47 / Termination Report 48
Auxiliary Services 51
Community Resources 51 / Parent Workshops 51 / Child Care 54 / Moving Service and Donations 55 / Home Repair 56 / Surrogate Siblings 56 / Surrogate Parents 58 / Mental Health Consultant 59
Follow-up Modes 60
Summary 60

PART II
Descriptive Statistics, Evaluation, and Outcomes 61

Introduction 62
PART II A
Descriptive Statistics: Results, Population, and Services / Rosemarie Relich 63
Results of Service 63
History of placement 63 / Frequency of Client Problems 64 / Disposition of Total Caseload 65
Description of Population Served 66
Demographics: Family 66 / Table II:1 Termination of PACT Services 68 / Demographics: Children 70 / Table II:2 Reading and Vocabulary 72
Descriptive Statistics of Services 73
Initial, Intensive Visiting 73
Initial Visits 73 / Intensive Visiting 73
Auxiliary Services 73
Parent Workshops and Child Care 73 / Table II:3—Descriptive Statistics of Services 74 / Surrogate Siblings/Parent Programs 75 / Donations, Home Repairs, and Moving Services 75 / Mental Health Consultation 75 / Newsletter 75 / Developmental Assessment Services 75
Summary 76
PART II B
Evaluation of PACT's Intervention Procedures for a Four-Month Period / Paul T. Giblin and Lawrence L. Biasatti 77
Selection and Characteristics of Sample Families 77
Evaluation Criteria 77
Data Instruments 78
Table II:4 PACT Evaluation Flow Chart 79
Initial Visit Data Form / Monthly Assessments 80
Daily Activity Record 81
Admission Form 81
Home Stimulation Inventory 81
Child Social Adjustment Scale 81
Parent Interviews 81
Termination Report 82
Inter-rater Reliability 82

Results 82
Assessments of Change and Intervention Procedures for the Total Sample Population 83
Assessments of Change and Intervention Procedures for Subgroups formed by Variables Present at the Beginning of Service 83
Subgroups Formed by Variables Dependent Upon PACT Counselor Ratings 85
Subgroups Formed by PACT Counselor Teams 86
Discussion 86

PART III
Conclusions and Implications / Esther Dean Callard 91

Selection of Clients 92
Duration of Service 94
PACT Service Emphasis 95
Professional Orientation 97
Evaluation 99
Relationship to Other Services and Agencies 101
Preventive Measures 101
Community Resources 102
Overwhelmed Workers 103
Recommendation 104

APPENDICES

A: PACT Project Roster 106
SERVICE FORMS
B: PACT Program Flow Chart of Services 108
C: PACT Referral 110
D: Review of Social Services Record 112
E: Consent Form to PACT Project 120
F: Needs Assessment 121
G: Monthly Update Report 124
EVALUATION FORMS
H: PACT Admission Form 126
I: Inventory of Home Stimulation 130
J: Child Social Adjustment Scale 133
K: Initial Visit Form 135
L: Family Strengths 142
M: Daily Activity Record 145
N: Monthly Assessment 148
O: Social Service Evaluation 153
P: PACT Termination Form 154

REFERENCES 165

Preface

The concept of PACT was first introduced to its parent institution, the Department of Family and Consumer Resources of Wayne State University, by the sponsor, Wayne County Department of Social Services (WCDSS), in the winter of 1977. Its funding began in June of that year.

It is important to point out in this statement that a complex program, such as PACT, could not have come into existence and started to operate effectively in such a short period of time, if certain enabling elements had not already been in place.

Ralph Patterson, Director of Children and Youth Services of WCDSS, authorized Ernestine Moore, now Program Manager of Placement Services, to search for an appropriate academic department at the university level to tackle the task of aiding families whose children were in foster care or were at-risk of placement, due to the family's inability to provide a wholesome environment for the child. Miss Moore conceptualized the nature of the service needed: intensive, short-term, home-based, focused on supportive education in areas of child care and discipline and home management. Due to a long history of good working relationships between social service agencies and the divisions of Wayne State University, in general, and the School of Social Work, in particular, Miss Moore enlisted the aid of Marian Reavey, Professor of Social Work.

Again, an already functioning alliance facilitated action. Wayne State University has an interdisciplinary Council on Early Childhood on which Miss Reavey is an active representative. Thus, her first hand acquaintance with programs in other divisions in the university, enabled her to identify and make ready contact with an appropriate academic unit, the division of Human Development and Relationships within the Department of Family and Consumer Resources. Thus, Miss Reavey was able to provide the connecting link between perceived need and potential resource, and, personally, bring the necessary people together, facilitating communication across disciplines. Anne Linn, also a member of the Council on Early Childhood, was then recruited to add her expertise gained from establishing a child care curriculum which utilizes intensive field work. She contributed practical suggestions regarding organizational structure and training format.

It can be seen that established working relationships based on a commitment to interdisciplinary training greatly expedited PACT's inauguration. Another facilitating factor was the immediate response of the research faculty within the Human Development and Relationships Division. Dr. Paul Giblin, Dr. Melissa Kaplan, and Dr. Kathryn Urburg promptly formed an evaluation team and, with the Principal Investigator, defined the theoretical framework underlying the project's service goals, chose suitable measures, constructed data collecting forms, and trained students to administer the instruments to be used in pre-tests.

The authors of this report wish to express appreciation to all the individuals, the offices and units within the university and the social service system which have supported PACT's efforts to help distressed families. Although the list is too long to enumerate in the Preface, a roster of all persons identified with the project appears in the appendix.

E. D. C.
February, 1979

Introduction

Esther Dean Callard

PACT—Parents and Children Together—is a highly appropriate acronym for the program for which it stands. It is a project which provides intensive, home-based intervention service to low-income families who have, or are at risk of having, a child placed in foster care due to inadequate parenting or an unwholesome home environment. PACT home counselors try to bring about positive changes in the child-rearing practices and home-management skills of parents so that the child(ren) may safely remain with or be returned to natural parent(s). That is, the project's basic goal is to keep *parents and children together.*

In funding this project the Wayne County, Michigan Department of Social Services is responding to a well-documented need for programs that encourage alternatives to foster care. It is obvious that the number of children placed in foster care due to inadequate home care is growing (Lash, 1976; Wiltse, 1974); that these children often spend years "drifting" in this "temporary" care system (Shapiro, 1976; Sherman, 1974); and that this is costly to the community and damaging to the child (Fanshel & Shinn, 1972; Polansky, 1975).

PACT is an experimental demonstration project which addresses itself to the above problem by trying to improve the conditions which have caused or threaten to cause the child(ren)'s removal from the family. It is based on the following assumptions:

1. Children have a basic human need to belong to someone who wants them and can care for them, someone with whom a deep and stable attachment can be formed (Bowlby, 1969; Fraiberg, 1977).
2. The child's biological parents have the primary right to the child and are apt to be the most willing and long-lasting reciprocators in this attachment (National Research Council, 1976; [Michigan] State Child Care Study Committee, 1976).
3. Strong as the bond between parent and child may be, many parents are faced with such grievous problems and debilitating situations that they are overwhelmed and unable to provide adequate care (Gil, 1975; Pavenstedt, 1967).
4. Such parents, though they may have the desire and ability to keep or regain a child, with supportive service, are frequently not given this service (Gruber, 1978).

PACT endorses the principle that the biological parents should be given every possible assistance and support so that removal of the child from her/his own home is a truly last resort alternative. If, however, despite the best efforts of the social service workers, PACT counselors, and other auxiliary medical and rehabilitative services, professional judgment is that the home environment places the child at risk of further abuse or neglect, the goals of the project, to keep parents and children together, must be superceded. The best interest of the child is the higher priority. PACT's role in this instance is to assist the Department of Social Services by documenting the evidence as to the nature and extent of intervention service that has been provided, the condition of the home, and the needs of the child.

Although there are certain family situations not responsive to remediation, there is evidence that programs which incorporate intensive service to distressed families can be

effective (Jones, 1976; Pike, 1977; Stein, 1976; Wagner, 1976). In designing the PACT project, these programs have been examined and many of their features have been incorporated. However, PACT is not a replication of any existing program.

PACT is unique in a number of important respects. First, it is directed and staffed by persons trained, not along traditional social work lines, but in the field of child development and family relationships. It is housed in the Department of Family and Consumer Resources, in the College of Liberal Arts, Wayne State University. The Principal Investigator and members of the evaluation team are faculty members in the Human Development and Relationships Division. Faculty in other curricula, such as Nutrition, Housing, Clothing, and Consumer Affairs provide consultant services; and the resources of the department, i.e., child development centers, food preparation labs, and a consumer resource center are available to the project. Thus, PACT is sponsored by and draws its staff from a department which has expertise in the areas so often cited as deficient in the families usually served by social service agencies: child-rearing and home-management (National Research Council, 1976).

PACT's Director and Associate Director have both earned Master's Degrees in the Human Development and Relationships curriculum. Their degrees, plus extensive experience in the delivery of social services, qualify them to teach the courses in which all home counselors are enrolled. Counselors are recruited, for the most part, from advanced students in the Human Development and Relationships program. However, the project's service needs take precedence and, if a qualified H.D. & R. applicant is not available, students with backgrounds in such related fields as education, psychology, sociology, or social work are considered. This is in accord with one of the goals of the project, that is, to provide an interdisciplinary approach to professional education and service.

Consistent with the interdisciplinary emphasis of PACT, consultants from various units within the university, such as Social Work, Law, Nursing, Psychology, and Medical Specialties are utilized as needed. The advantages of drawing upon relevant disciplines when dealing with the complex problems of child-parent-environment is currently emphasized by social workers and policy makers advocating for children (Chilman, 1973; Himelrick, 1976).

A second unique and highly important feature of the PACT program is its strong emphasis on a supportive interpersonal relationship between home counselors and the family member receiving service. The effectiveness of such a relationship has been cited in various intervention projects (Jones, 1976; Sherman, 1974). In forging a trusting relationship, the PACT workers have a great advantage. PACT is a voluntary program and clients are selected on the basis of their declared desire to maintain custody of their children. Thus, the counselors are able to present themselves as allies, having the time, the skills, and the single purpose of joining with the parent in achieving their mutual goal. The parent realizes that the PACT counselors have no direct control over public assistance allotments or custody decisions. They are friends and facilitators, able to locate services, intercede with agencies, and if the need arises, actually provide some forms of assistance; they work within social agency rules and in the best interest of the child involved. Thus, the home counselor becomes a model, directly demonstrating the behaviors that, if incorporated by the parent, will help to create and maintain a wholesome home environment and an intact family unit.

A third feature of the PACT program, one which greatly enhances its chances for effectiveness, is its flexibility, i.e., its capacity to be responsive to individual needs, to be
8 innovative and experimental. The original PACT proposal explicitly defines basic goals and

objectives. The service components and personnel roster are, however, quite deliberately indicated in general, rather than specific, terms. This allows for maximum latitude in selecting strategies, services, and personnel according to client needs. To illustrate: although not explicitly described in the original proposal, the program has been able to identify and respond to the need for such service elements as surrogate siblings for particularly troubled children, parent workshops, and a repair crew to do simple but vital home maintenance.

The personnel budget is so constructed that consultants may be brought in according to the revealed needs of both clients and counselors. As the counselors enlarge their personal knowledge and increase their expertise through course work and field training, funds originally used for outside consultants are diverted to expansion of service delivery. This flexible method of program evolution insures that monies continue to be used in the most appropriate and effective manner possible.

PACT has a fourth feature which insures against an irresponsible lack of goal-directedness or accountability. That is, PACT incorporates a multi-faceted system of case monitoring: (a) as students in training, home counselors are required to prepare detailed problem statements, treatment plans, and progress reports; (b) counseling teams meet periodically with the Project Director and Case Work Supervisor to review the status of each family, critique approaches, and redefine objectives; (c) joint monthly staff meetings are held with the home counselors to discuss service or administrative deficits and institute needed changes; (d) the Principal Investigator periodically reviews case files, meets with home counseling teams, and assesses needs for program modification with the Project Director; (e) the Wayne County Department of Social Services, which assigns families to PACT, monitors the service delivery through monthly service reports on each family and quarterly progress reports on the entire project. Such a schedule of progress review, which would ordinarily constitute a luxury and a redundancy, is essential in an experimental program which has a commitment to both service and demonstration (Shynne, 1976).

Throughout the case monitoring process, the progress of our intervention is measured against PACT's basic goals and specific objectives.

PACT's basic goals are to:

a. maintain children who are at risk of placement in foster care in their own family
b. return children who are in foster care to their biological family
c. in the event that the family cannot retain or regain the child, document the services toward that end rendered by PACT, thus providing information that may assist the Department of Social Services and the Juvenile Court in making permanent placement plans for the child

The project's specific objectives are to assist in creating a wholesome environment for the child through improving:

a. the family's ability to organize and maintain a safe and healthy home environment
b. knowledge and skill in low income budgeting
c. sensitivity to child's needs
d. utilization of appropriate management and discipline techniques
e. health and nutrition standards
f. use of community resources

The design for evaluating PACT's progress toward meeting the above goals and objectives follows the traditional model utilized in social service projects:

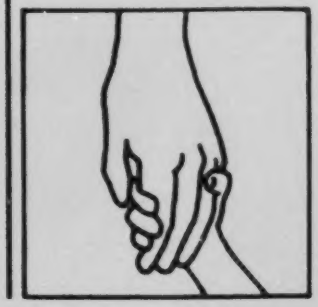
a. goals and service objectives are operationally defined
b. initial status of the client is assessed and critical problems identified
c. ongoing records are made of service input in terms of *nature* of service and *approach* utilized by counselors
d. periodic progress assessments are made by counselors in collaboration with supervisory and auxiliary staff
e. termination reports assess the status of the family and indicate reasons for termination

In Part I of this report Morin describes how staff members are selected and trained to provide PACT's service; how goals are formulated for each family; and how objectives are met. Part II, dealing with evaluation of the project, consists of two distinct reports. Relich provides descriptive statistics on the client population, delivery of service, and status outcomes. In addition to this traditional method of reviewing social service programs, Giblin and Biasatti provide a report on a research project involving fifty-one families studied over a four-month period. In Part III Callard offers conclusions and implications for changes in the PACT program and for service to families in a broad social context.

This report describes the PACT project and its results in sufficient detail so that worthwhile aspects of the program can be replicated. However, the project model should not be considered a *product;* it is a model of a *process.* It is based on its capacity to be *responsive,* not tied to inflexible program components, client-counselor interaction strategies, or personnel rosters. Thus, it presupposes that a high level of professional skill and judgment be exercised by its administrators, its counselors, and its evaluators. It also presupposes that this professional expertise be in areas appropriate to the service needs, in this case, the areas of child care and development, family relationships, and home management.

PART I

PACT
The Service Model



PACT
The Service Model

Patricia E. Morin

Introduction

A program designed to deliver intensive services to low-income, problem families confronts diametric responsibilities. On the one hand, the population served falls readily into the broad classification of multiproblem families. Such families suffer from a lack of money and resources, poor nutrition, substandard housing, dirty and unkempt surroundings, over- or understimulated children, mental and physical disabilities, substance abuse, home and school truancy, and crime.

> The house the Sanderses are renting is in terrible shape and there is no hope that the landlord will make any repairs (he recently left the water bills unpaid and the family had to go without water for two weeks). Landlords are reluctant to accept ADC families as tenants, especially a family as large as this one: three adults and seven children. Because of health problems, Mrs. Sanders has twice passed up housing opportunities we presented to her. Besides this, Mrs. Sanders has been elusive and unpredictable, constantly failing to keep her appointments and ignoring our suggestions. Nevertheless, despite her minimal cooperation, our continued efforts were instrumental in the progress different family members were experiencing. Marie, a mentally disturbed daughter, is finally getting financial assistance. She was also evaluated and treated by a psychiatrist and has been showing relative progress. Betty, left physically and mentally handicapped after encephalitis, has shown strengths, and has developed her parenting skills to the point that her baby Timmy, a past failure-to-thrive case, pleased his doctor with the improvements. Betty has also started a physical rehabilitation program to improve her gait and speech. Richard, 16, and Louie, 14, both convicted a year earlier for armed robbery, are now out of trouble. Richard has been working in a summer job and Louie has gone to a summer camp.
>
> B. M. Lande

The multitude of problems may tempt the service program to adopt a philosophy which says in effect, "Be prepared for any and every eventuality," and run the risk of being ill prepared for particular situations. On the other hand, service must be specific and secured in sound theoretical principles while still being sensitive to individual differences. Causes of child-rearing, hygiene, or nutrition problems may differ from one family to another. Yet each of these frequently surfaces as part of the multiproblem family configuration and must also be viewed theoretically.

Inevitably service reflects program orientation in the determination of goals, objectives, theory and its application, and the selection of techniques. To ward off insularity, a program needs to attend to the findings of research originating from other disciplines and to invite outside consultation. Yet a common philosophical orientation can be beneficial in

its assurance that supervisors and workers will be sharing basic goals and purposes and that decision making at all levels will be in accord with overall project goals. Furthermore, program goals, objectives, and methods must be clearly stated for the sake of evaluation. Nonetheless PACT has found that a stage of experimentation with methods is more likely to secure a stable methodology than is an assumption that a program design in its entirety will work without a trial period.

PACT has attempted to meet these varying program needs. PACT's philosophical orientation is founded in a humanistic interpretation of family relations and the development of children. All planning and service, whether directly or indirectly related to family relations and child development, tends to be viewed in that light. As a balance, the program, stationed in an academic setting, has consistently sought interdisciplinary input and approaches to service through consultation and incorporation of a variety of processes and techniques from other disciplines as well as cross-departmental hiring for various project positions. Furthermore, while goals and objectives have been clearly stated from the program's inception, PACT has been allowed latitude in experimenting with treatment methods. Much of the service content therefore is a response to emerging client needs. As will be seen from the following, the desire to integrate theory and practice consistently influences the selection of project staff and the organization of services.

Training and Preparation of Staff

Personnel

With the project's family-child focus in mind, staff administrators have been selected to enhance the potential integration of theory and practice. The principal investigator, Esther D. Callard, Ph.D., is the former chairperson of the Family and Consumer Resources Department (FAC) and teaches courses in child development and family relationships. She has been director of the department's childcare facilities for infants, toddlers, and preschoolers, and is the prior principal investigator of a social services grant to train childcare aides in Wayne County, Michigan.

The project director, Patricia E. Morin, holds a master's degree in human development from FAC. She has worked as a child development consultant and social worker, and has considerable experience in direct service to low-income parents and children. She is the former assistant director of a supplemental foods program for low-income families.

The associate project director, Rosemarie Relich, also holds a master's degree in human development. Her duties are twofold: administration and evaluation. In addition to certain regular administrative responsibilities, she assumes management of the project in the director's absence. However, her major responsibility lies in supervision, coordination implementation, and monitoring of the evaluation plan. Relich's master's thesis evaluated certain aspects of behavior in abused and neglected children. She also has experience as a research assistant and interviewer in a nationally funded project studying child abuse.

The coordinator of PACT's parent workshops, Barbara Sugerman is a master's degree candidate in human development. Her duties include designing, scheduling, and conducting three parent workshops per week. In addition, she is responsible for reporting weekly on the content and outcome of each workshop and assisting in the design and implementation of a workshop evaluation. Mrs. Sugerman's academic specialization is in parenting

education, and she possesses considerable experience in developing and directing parent workshops. She worked for a year as a counselor in PACT.

The casework supervisor, Susan L. Pearson, holds a bachelor's degree in human development. She is in charge of intake and referral and supervises the counselors in their day-to-day contact with clients. Pearson's background includes the design and development of a substance abuse program, board chairmanship of this program, case management in service programs for low-income families, and direct services. She previously worked as a counselor in PACT.

The PACT staff also includes a driver who transports parents and children to and from the parent workshops and is foreman of the home repair and donation services; an administrative assistant who works as a bookkeeper, money flow manager, personnel processor, message keeper, report transcriber, and part-time child care worker; and a clerical worker who assists the office manager.

In addition, the PACT program has utilized contractual services monies to augment core project services through enlistment of a variety of consultants. In general these consultants fall into three categories: evaluation, education, and direct services on a part-time basis.

Evaluation consultants have assisted in the development of the project evaluation design. They include the principal investigator, Dr. Callard, and three FAC faculty members: Paul Giblin, Ph.D., Melissa Kaplan, Ph.D., and Kathryn Urberg, Ph.D. Giblin, along with a research analyst, Lawrence L. Biasatti, and Relich, the associate director, has completed part of the evaluation which appears in this manual. Education consultants have been utilized for initial and ongoing training of the staff and for case consultation. Through both consultation with these professionals and the aid of direct service consultants, the project has been invested with a multidisciplinary approach to service. These consultants include faculty from the Wayne State University departments of Family and Consumer Resources, Psychology, Education, and Sociology, and from the schools and colleges of Social Work, Medicine, Law, Nursing, and Education. Consultants have also been drawn from the Board of Education, the City Department of Health, the Department of Social Services, and many community agencies and other universities. Direct service consultants are drawn from a variety of disciplines within the university and staff part of PACT's auxiliary services, such as home repairs and donations, surrogate siblings, child care, and mental health.

Selection and Training of Counselors

PACT seeks individuals who are capable of adapting to and gaining control over a complex treatment process and who are preferably advanced students in the human development program of the Family and Consumer Resources Department at Wayne State University. Uniquely suited to the work to be done, the human development curriculum includes courses in all phases of child development, parenting, family living, nutrition, and consumer education, as well as cognate courses in psychology, sociology, social work, and health. Many child development and parenting courses offer real-life experiences with parents and children. However, if enough applicants are not available from the human development program, the project invites applications from other related disciplines, such as social work, psychology, education, nursing, criminal justice, guidance and counseling, and sociology.

In addition to particular personal qualities and academic preparation, the project seeks applicants who have had at least six months' to a year's voluntary or paid experience working with low-income parents and children. This experience may have been obtained

in courses such as the curriculum practicums. The applicant also needs to have some knowledge of social work parameters.

Applicants for the position of PACT counselor are required to submit a resume and complete a standard application form. At the outset of the project applicants were screened and interviewed by the principal investigator as well as the project director and associate director in order to establish guidelines for hiring. Thereafter, interviews were the responsibility of the director and associate director.

To ascertain the applicant's capabilities, criteria are applied based on a task description of the PACT counselor as per the following scale:

Criteria for Counselor Selection	*Rating of Ability* Poor / Fair / Good / Excellent
1. Responsibilities to project:	
a. report an account of each home visit	
b. conduct interviews and perform observations	
c. record keeping for social services	
d. ability to review health records	
e. drive and have a car	
f. available at odd hours	
g. personal characteristics:	
—literate	
—discreet	
—punctual	
—responsible	
—tactful	
—conscientious	
2. Responsibilities in home visits:	
a. Information:	
—knowledge of child development	
—nutritional needs	
—consumer skills	
—health symptoms	
—community	
—parameters of social work	
b. Skills:	
—ability to play with children	
—homemaker skills (cook, sew, etc.)	
—instruct in an organized, clear manner	
c. Interpersonal:	
—strength—confidence—something will be done—positive attitude	
—willing to deal with feelings	
—lack of naivete, sophistication	
—persistence, high frustration tolerance	

—not too vulnerable
—not too overwhelming (responsive to feelings of others)
—energetic
—intact
—charismatic

In addition, the applicant's problem-sovling ability is assessed. This ability is constantly challenged in developing treatment plans for multiproblem families, for it involves both the capacity to foresee consequences and thereby identify something as a problem, and a breadth of knowledge which will help identify the solution most likely to alleviate or remove the problem. Problem solving is therefore a process involving both creative talent and analytic skills. The sample problem requires the applicant first, to identify the problem and its potential consequences; second, to list several possible solutions; third, to select one solution that is most likely to alleviate the problem; and fourth, to give reasons for this selection. The applicant is forewarned that the problem has no absolute right or wrong answer and that the particular sample was chosen because it focused on the applicant's knowledge of child development. It also typifies the kind of problem which counselors frequently face.

Finally, the applicant's written and verbal communication skills are assessed. Oral communication is one indication of how skillfully the applicant will be able to handle verbal exchanges with clients. In addition to observing the applicant's verbal skills throughout the normal course of the interview, the project director, associate director, and possibly one other staff member converse with the applicant, whose performance is afterwards rated separately by the three staff members. Because routine reporting on client status and progress is an essential part of the counselor position, the applicant's written communication skills are also important. In part these skills are assessed from the problem-solving exercise. The applicant is also required to write two pages completing the following sentences:

1. The position of PACT counselor appeals to me because . . .
2. My responsibilities as a PACT counselor will most likely include . . .
3. I am qualified for this position because . . .

This exercise not only measures communication skills but brings out some of the qualities sought among the character and personality indices. The sentences are scored separately by three staff members who have not had contact with the applicant. The measures primarily assess the applicant's sense of organization, grammar, vocabulary, spelling, and sentence structure. Secondarily, the measures assess the applicant's sense of reality, convictions, perceptiveness, lucidity, state of involvement, facility, knowledgeability, self-awareness, analytical ability, and persistence.

Academic Training

PACT offers a year's internship in training for human services. In general the goal of training is to prepare counselors to qualify for leadership roles in the human services field, particularly where child development and family relations are a principal focus. The objectives of training are to develop or enhance the trainee's ability to:

1. form positive and nonjudgmental relationships with others
2. understand the complex nature of stress experienced by multiproblem families

3. assess problems and strengths and design appropriate treatment plans
4. develop the skills and techniques necessary to deliver a variety of services
5. treat special problems
6. make discriminative selection of treatment strategies and use them effectively
7. function effectively and efficiently in relation to organizational control of caseload, integrative treatment planning, and maintenance of personal morale
8. write clearly and informatively in client reports, class papers, and evaluation reports
9. utilize community and other resources

Some trainees also are selected to develop further their skills in counseling, formal developmental assessments, supervision of training, group processes, program development, administration, evaluation, and public relations.

The content of the training has evolved as the specific needs of intensive service emerged and is therefore a response to the realities of the job. The formal structure is provided through four academic courses. All trainees are enrolled in the same curriculum for the first three courses (and quarters) of the internship. The third course may or may not be taken for credit if trainees wish to substitute credit courses in related subject matters from other university departments. However, the trainees are still required to attend the PACT course. Counselors are selected for the fourth course, advanced training, if they demonstrate exceptional abilities. The remaining counselors continue in the third course which is extended to the fourth quarter and runs simultaneously with the advanced training course. Neither of the last two must be taken for credit, but again trainees must attend the classes and substitute another credit course.

The courses offered within PACT are:

An Interdisciplinary Approach to Child and Family Services. Course Content: Intensive training in child-family intervention procedures in the following areas: parenting, child development, nutrition, money management, home maintenance and improvement, health and hygiene, use of community resources, dynamics of family interaction, sources of family dysfunction, intervention techniques (counseling approaches, modeling and demonstrating, reeducation, behavior modification, creative listening, assertiveness, coercive persuasion, confrontation), development of basic trust, contracting, reviewing and assessing client status and progress, reporting procedures, developing service plans. Role-playing, visual aids, game playing, value clarification, etc., included. The course meets four days a week for three hours at a time for four weeks: and once a week for the remainder of the quarter.

Workshop in Child and Family Intervention. Course Content: Field observation with service providers of the Parents and Children Together program. Evaluation of experience. Practice in completing assessments, contracts, service plans and reports. Field experience with assigned clients. Twice monthly review and assessment of trainees caseload in relation to a family and child development perspective as well as development of comprehensive service plans. Integration of services. Once-a-week lecture and discussion with visiting consultant on relevant topic.

Advanced Workshop: Societal Systems and Their Impact on Child Placement. Two Quarters. Course Content: Individual investigation, group discussion and community consultation related to economic, social, political and legal systems which influence family welfare and child placement policies. Investigation, analysis and

possible resolution of particular problem areas in relation to these systems and service. Further refinement of service strategies, processes and techniques. Once-a-week discussion.

Seminar: Advanced Skill Development in Child and Family Services. Course Content: Skill development in counseling, formal developmental assessments, supervision of training, group processes, program development, administration, evaluation and public relations. For selected counselors.

In addition to the formal structure of the courses, training occurs in many other ways, including monthly supervisory sessions, mental health consultation, consultation with faculty from the Department of Family and Consumer Resources and other university departments, attendance at workshops and conferences outside the project, and exposure to a variety of tasks, some of a supervisory nature.

Once the internship has been completed, counselor-trainees are awarded university certificates stating their accomplishments and preparation for specific jobs. PACT and the Department of Family and Consumer Resources hope that the care taken in training its counselors and the demonstration of the program's achievements will influence policy and decision makers to establish standard governmental and private career opportunities in human services for students who have been prepared in child development and family relations curricula. To emphasize the merits of this academic preparation combined with service training, PACT intends to publish a detailed training curriculum at a later date.

The Counselor's Role

The counselor's job is complex, encompassing several major responsibilities. Most of these will be discussed more fully later in this part of the report; they are mentioned here only to give an overview of service. Foremost among counselor reponsibilities is the development of the counselor-client relationship, which is central to the delivery of project services. Second is to assess, under supervision, the competencies of the client and/or family in areas related to management of the household, and the physical, social, and psychological development of family members. Third is to set goals and develop treatment plans and strategies for meeting the goals of service.

Goal setting and treatment planning are possibly the most complex of counselor responsibilities. Both involve the organization of the treatment plan so that goal attainment follows a logical and evolving course of development founded in theoretical principles, specific responses to client needs, and confinement to anticipated timelines. Effective goal setting and planning allow maximum utilization of project and external resources.

The fourth responsibility is the day-to-day delivery of services (i.e., the implementation of the treatment plan). This includes frequent face-to-face contact with the client and family; the provision of direct services such as transportation to and from clinics, agencies, and foster homes, for example; arranging for donations and home repairs as warranted; and advocacy vis-à-vis the public, social, legal, and medical services, the schools, and the courts. Daily responsibilities also include close collaboration with the Department of Social Services referring worker and other concerned agencies, and setting up contracts with the clients.

Additional counselor responsibilities include frequent review and assessment of client

progress, documentation of all that is observed and transpires in relation to assessment and service, and evaluation as to when service is no longer justified or needed.

While each of the foregoing will be discussed more fully in the text which follows, more needs to be said here about another aspect of counselor responsibility—the teamwork approach—which is perhaps the strongest bulwark of project service.

The Teamwork Approach

The counselor is engaged in two types of relationships which supply the contextual framework for service. First is the counselor-client relationship, and second, a teamwork construct within which all service occurs. Actively cultivated by the counselors, the teamwork approach occurs at three levels:

1. The counselors work in teams of two, thereby increasing accessibility to the client and other service workers, the depth of planning and organization, and maintenance of counselor morale.
2. The entire project functions as a team in extending a variety of services to the client, sharing information about client progress in formal and informal group sessions, and developing strategies, processes, and techniques.
3. The cooperative client becomes part of the team, which both supplies a motivating force and tends to remove some of the animosity clients may have felt toward "the system."

PACT currently employs ten counselors, with each two-counselor team sharing a maximum caseload of twelve clients. Clients are counted by family rather than by individuals; if the latter method were used each team would have an estimated caseload of sixty, considering there is an average of four children in each family. The team structure first arose out of discussions among evaluators, supervisors, and the first group of PACT counselors. Even at the outset it was seen as a temporary measure to maximize moral support as the counselors gradually adjusted to their role. Evaluators and supervisors anticipated that once caseloads reached their maximum, the demands of frequent client contact would force counselors to abandon the team approach. However, when maximum caseloads were reached within two months, the counselors unanimously voted in favor of retaining the teams, with the commitment that service requirements would be efficiently divided and organized. Often the subtle nuances of close friendship develop between the two members of the team.

> For two weeks now we have been soliciting everywhere for a good used refrigerator. There must be at least one in this city we could have. After all, this young mother-to-be can't keep any fresh foods and milk for more than a day in her hot little apartment, and nutrition has been quite a problem for her. In addition to that, the nearest grocery store to her is at least 10 blocks away and she is supposed to be staying off her feet.
>
> I was just about to call back a possible lead when Sue walked in. "Guess what!—We've got a refrigerator!" "All right." I hung up and stopped dialing. She had come across an old industrial type refrigerator that was "pretty big" but ran well. "It's free, too," she said, "but I think it's gas run. Does that sound right to you?"
>
> A quick consensus of professional opinions in the office gave us the answers: "I've never heard of that, are you sure you heard right?" "Yeah maybe, I think my grandmother had one." "Gas refrigerator?" So we called the gas company.
>
> I have to admit feeling a bit embarrassed, but of course I approached the

Home Service Department rather professionally and asked what the procedure and cost was for installing a gas refrigerator. To my surprise the woman's voice said matter-of-factly, "Just one moment please." She came back with "That should be about $32.00; give us one day's notice."

As is normal around our office, Sue was taking a call from a client, completing forms, trying to reach a caseworker from the Department of Social Services on another case, and eating her share of our hard-boiled eggs and V-8 juice lunch. I quickly filled out a request form for the PACT furniture movers to pick up and deliver the refrigerator that Friday, and made a note to call the gas company back on Monday and to schedule a visit to alert our client to be on the lookout for our movers this Friday. We had another visit to make in twenty minutes and left.

Friday noon Matt called. Matt is unique. His functions include being a big brother, doing home repairs, driving the pickup vans for workshops, hauling donations, and moving furniture and household belongings for our families. He is also thought to be our resident hippie, with long black hair and antiestablishment clothing.

"Do you guys there know that it took five guys to haul this blank refrigerator in this kitchen? It will never come out of here, you know! And what the devil is this bit about a gas hookup? If you tell me I wasn't supposed to deliver this . . . I mean, are you guys sure you know what you are doing?"

He sounded so exasperated, I couldn't help but burst out laughing. "It's o.k., Matt. Really. How big is that thing?" Well, he gave me quite a description and stated again something about the fact that no one would ever be able to get it back out again.

We thanked him profusely and hung up. Sue had been sitting nearby and heard me talking. First thing I knew she got that mischievous grin on her face. She picked up the phone.

"Hello, Save Realty?" Then she identified herself. "Yes . . . well, I'm calling in reference to that apartment over on Seward . . .

In five minutes she had convinced the realtor who owned the building to pay the installation charge for their newly acquired refrigerator. After all, from now on it was a permanent fixture!

D. Miller

The team approach offers many built-in advantages, of which the most important are ongoing mutual moral support and the opportunity to complement the training and academic background of one team member with that of another. Furthermore, client observations and assessments tend to be more reliable. Other benefits include:

1. A stubborn situation may submit to the fresh approach of the "other" team member.
2. Counselor accessibility to the Department of Social Services worker, to other agencies, and to the client is doubled.
3. Day-to-day strategy is enriched by the knowledge and interaction of two minds.
4. Service and contacts are not interrupted when one counselor is unavailable.

These advantages have been experienced over and over by PACT, especially when emergencies arise. Team involvement demands persistent commitment and effort from the counselors. Generally, the team caseloads of twelve families are divided, with each team member primarily focusing on six families. Yet each makes periodic visits to the other six families so that both team members and all twelve families know each other. Joint visits

occur for other reasons also. For example, one team member might be able to lend more expertise to solve a particular problem than the other; the neighborhood might be more dangerous for one than two; or, one team member might find it easier to visit with the parent if the other occupies the children.

Not only do the counselors work in teams, but the entire project functions as a team. Supervisors and counselors form teams for the purpose of reviewing and assessing client progress, brainstorming knotty problems, and establishing future strategies. Everyone shares in training new staff. Also, every treatment plan in one way or another involves the workers responsible for delivering PACT's auxiliary services.

> In my work at PACT I've found my most valuable resources to be the advice, opinions, and availability of other PACT counselors. All of us work closely, and when a case gets difficult or I've had a particularly frustrating day, I find it helps to use the other counselors as sounding-boards.
>
> I remember one time when one of my clients was drunk, hysterical and possibly threatening suicide. I felt responsible for her and kept searching for a way to help her. Discussing the case with other counselors made me realize that I was not responsible for what the client did with her life and that providing support was all I could do in the situation.
>
> In addition to talking over problems, the other counselors also provide me with tips on where to go for other services needed by my clients. Once I needed to find cheap, but large and clean, housing for a client in order that her son could be returned from foster care. After I exhausted other resources, a coworker told me about a rental agency she'd found success with, and I called the same day. Sure enough, they had just the kind of place the client needed, and the family moved soon after.
>
> These are but a few of the many times I've received help from the other counselors. All ten PACT counselors seem to work as a team, supporting and gaining support from the others. This additional benefit of the job keeps me less tense and frustrated when a difficult situation arises, and I am thus able to provide my clients with better service.
>
> D. Kade

Eventually, the client becomes part of the team effort. As concrete progress is made, the client's desire to be involved in the planning and implementation of service increases.

Control of Caseload

Though each individual counselor has only six clients, intensive service requires a tremendous investment with each of them. Containing the job within reasonable time and emotional limits becomes a paramount issue. Several factors must be accounted for in relation to control of caseload, among them controlling the depth of client dependency on the counselor, ensuring the flexibility to meet new problems and crises, providing time for recording, case documentation, additional duties, training, assignments, and maintaining morale.

The work can assume immense proportions, and care is taken that clients' demands do not consume the counselors. Although some dependency is encouraged at first, services performed for the client are generally balanced with client-performed tasks. Even the services performed are done with the purpose of giving the client a basis for accomplishing objectives. Service in this sense is like a game of building blocks. Gradually the client is
22 encouraged to place more and more of the blocks. Most blocks correspond to the service

categories offered by PACT. At least a few of the blocks represent enduring community resources which the client might turn to when PACT is no longer part of the client's structure. A similar building process occurs in the parent workshops and other service components.

Flexibility cannot be planned in the same way, but it is at least a counselor attitude in the sense that the unexpected is anticipated. Such a prepared attitude helps the counselor adjust when crises rearrange a whole day's schedule. Sufficient lead time for deadlines is essential. Paradoxically, providing counselors with a month's calendar of scheduled project meetings, workshops, training sessions, home repair and moving days, and mental health consultant hours helps them maintain flexibility. All is not sand; the job has a structural framework. The calendar, because it reflects service from other project components, also helps the counselors vary the kind and intensity of service for each client. Service to the client in any one week might include counselor visits, parent workshop, childcare, home repairs, donations, and surrogate service. Thus service is not totally borne by the counselor, although he or she is responsible for its management. Some clients might need as much or more service from these components as from the counselors. Such a spread in service facilitates variation in intensity of services for the counselor.

Intensity of service is also affected by the progress of clients and their length of time in service. In assigning cases, supervisors attend to varying the intensity of counselors' caseloads so that a team with two or three highly intensive cases at a given time is temporarily passed over for new assignments.

For evaluation purposes, PACT counselors are required to complete daily and monthly data forms on their clients. They are also required to submit written reports every six weeks to the referring Department of Social Service workers and routinely document case intervention in the event records are needed for juvenile court. Counselors must appear in court to testify. Because of these strenuous demands on counselor time, supervisors are continually available to help organize cases efficiently, relate ongoing service to specific goals, and offer moral support.

Time Budgeting

After one of PACT's periodic meetings about budgeting time, the following was preferred anonymously:

> So much is said and written in professional circles about budgeting time that an expectation of turning minutes into nickels almost invades one's sense of reality. Can you imagine people going up to a time exchange machine, saying, "I've got three hours," and a slew of nickels comes out of the slot? Perhaps there could be a time market as well as a stock market. Lucky investments yield increasing amounts of time. Of course those with more time to invest would obtain a greater return.
>
> It's a delusion to think of time in analogy to money. Meetings, service to clients, classes, workshops, etc., may be scheduled with an allotment of time, but time is not comfortable with being budgeted. It screams and squeals and kicks at the person who tries, and finally lays him flat with an ulcer or humongous cold (failing of the room rent). Time says, "You gotta give me a little more to absorb the frustration, or relax from that stress, or let off steam. I'm not used to such pressure. I like to take it as it comes, nice and easy, one at a time. And every once in a while, hopefully more often, I like to throw it all over, and go for a beer with the gang. I also enjoy being used creatively, listening to some good music, painting a picture, or performing in a show! It's easier on the ticker." Time resists being crowded into small spaces and has a way of pushing some things aside in order to make more room.

Time does tend to elude rigid structuring, and hence the pervasive concern about getting time under control. Nevertheless, anyone with a job to perform needs to develop a system for organizing the parts. In line with this objective, PACT recently conducted a time study. Each counselor was first asked to divide a pie into the size of parts (percentages) he or she estimated to correspond to the percentage of time spent on service, transportation, telephoning, meetings, and recording. The supervisors then asked the counselors to keep records of how their time was actually spent for the following two weeks. At that time, the counselors again divided the pies, but based on their records rather than estimates.

Most categories turned out to take approximately the same percentage of job time as had been estimated. The records showed that recording takes too much time (25 percent) and leaves less than desired for services to clients (25 to 40 percent). Telephoning in relation to service to the clients took from 14 to 20 percent, and meetings took between 10 and 15 percent. Transportation was very mixed, reflecting the differences in distance between PACT offices and the areas different counselors work in. Counselors also reported that additional duties for auxiliary services and meetings often pushed work hours over the forty-hour limit, which testified to the dedication of the counselors but also reflected the difficulty of containing an effective human service job within a regular work week.

PACT is now examining ways of reducing the office responsibilities of the counselor position and increasing the amount of direct service. For the counselors, the time study demonstrated that each was spending approximately the same percentage of time in the five areas, and any redistribution of percentages would have to involve an adjustment of responsibilities. For the time being, counselors shared the confidence of knowing how they must distribute their work week and of feeling that supervisors were attentive to the need enunciated by the study.

Few of the time pies included a percentage for relaxation, a jarring disclosure. In later evaluation meetings with the director, several counselors expressed a desire to have time to relax with other counselors and ventilate some of the job pressures. The supervisors agree that this is indeed a need, and yet have also observed that counselor morale seems quite high and staff turnover has been next to nil.

Staff Morale

Simply getting something accomplished is often as essential for counselor morale as it is for client improvement. Conveying material service of one kind or another often fulfills both these important functions. But sometimes the plans for this service go awry in a delightful way, providing the staff with a lot of good laughs. The following anecdote is about a 65-year-old man who has five children, including three younger ones at risk of placement. The father had just recently recovered from pneumonia and was overwhelmed with the care of his children and two grandchildren. The mother, estranged from the father, had been in prison for more than a year on a homicide conviction.

> At the beginning of intervention the family was living in a lower two-bedroom flat on Detroit's far east side. The flat was filthy, underfurnished, pest-infested and unsafe. The neighborhood consisted of many boarded-up vacant houses and some partially torn down structures. The home was located in a very high crime section of the city with known drug houses nearby. PACT contacted the Rent-Aid Supplement Program through DSS and found that Mr. Smith qualified for rent assistance, and then helped him secure it. When we realized that Mr. Smith could not find housing on his own, we found a flat for him, contacted the landlord and made arrangements for the family to move to new living quarters.

After all final arrangements had been completed, a PACT driver arrived on the pre-arranged day to move the household goods of the family to the new house. The family had not been able to prepare for the move—basically because they really didn't want to leave— they *knew* they had to, but they were still resisting. The driver of the van looked over the house, re-checked his orders and then proceeded to move the family despite the situation. Everything that fit into a garbage bag was moved, including the garbage.

The father had prepared for this traumatic day by fortifying himself with a liberal dose of alcohol and stationed himself in the doorway to "help." The six-year-old daughter packed up her pet dog in a plastic bag and loaded him on the truck; the driver was alerted to this fact by the howling under bags of clothes. The six-year-old son got into the spirit of the day by packing his sister in a bag and depositing her in the van.

When the truck was full, the driver asked any child who was not supposed to move—neighborhood children had joined the fun—to leave the van, then told the father to get on the van because today was indeed the moving day. The father, dog, three children, two adult members of the family, furniture and household goods then left for a new home.

The father didn't realize that he had moved for three days.

S. Meagher

A week or so after the move, the counselor observed the father out in front of the new house, mowing the lawn and trimming the bushes. He spoke enthusiastically about the plans he had for his new home. He hadn't been able to face the change, but when it happened despite him, he welcomed it. Both the client's situation and the counselor's morale were improved because a positive step was taken, and everyone on staff benefited from the humor of the situation.

The project has developed a number of support systems to help maintain and strengthen staff morale: the weekly group sessions, monthly supervisory meetings, mental health consultation, and team-member support. In addition, the project allows counselors a one-week "time out" for every six months of service. Project administrators inform the counselors that their responsibility for their clients is suspended during this period and that supervisors will handle emergencies. Counselors are urged to spend their time out productively, by catching up on class assignments and recording, reading materials related to project service in the library, and taking the entire week at a more relaxed pace. In general, this time out helps counselors gain perspective on their work in the project and provides them with an approved oasis of freedom from responsibility for their clients. While counselors conceivably could arrange their own time out, being granted permission for taking it and its regular provision increase its benefits.

Other routine support systems are included in the project service system. The additional duties assigned to each counselor provide work variety, which is also a benefit of varying treatment strategies. Furthermore, counselors are encouraged to take major responsibility for creating modules for treatment. One counselor developed a hygiene learning module for an especially unkempt household. Several more developed creative approaches to conducting family councils. Unique space arrangements and related treatment strategies were designed by others to meet family members' territorial needs.

Counselors are encouraged to think of themselves as part of the group, and to consider that individual morale can be affected by the level of group spirit, which is in turn affected by each member's contribution. Rather than allowing feelings of discontent to

fester, supervisors urge counselors to submit individual or group complaints for discussion. Because a distinction must be made between major and minor complaints, a grievance procedure has been established which requires that complaints be reasonably stated in writing. Answers to complaints are given at staff meetings one week following their submission. This time lapse gives supervisors a chance to investigate possibilities for meeting requests and to supply counselors with a thoughtful reply.

Finally, supervisors, including the project director, associate director, and casework supervisor, are consistently accessible. The doors to their offices are usually open, and counselors are free to discuss client, job, or personal problems. Such a permissive arrangement means that supervisors must hold meeting and conference time outside the agency to a minimum, a situation which poses a conflict, since consistent external contact helps build community, government, and foundation support. Supervisor accessibility, however, is enormously supportive of counselor morale.

Systematic Review and Assessment

PACT's training program includes two types of regular review and assessment sessions: monthly supervisory meetings and weekly or biweekly counselor workshops.

The monthly meetings maintain continuing supervision and control of the agency caseload. Each team of counselors meets with the director, casework supervisor, workshop coordinator, and other key auxiliary service personnel for a half-day review of the team's cases. The meetings have three general goals: to ascertain if treatment goals are being met, to distribute responsibilities appropriately, and to review and establish plans for integrating project and other services in light of the client's current status. Each meeting emphasizes coordination of services and sharing of perceptions regarding clients and client-child relationships and interactions. The current work emphasis is examined in light of the original or revised treatment plan. Supervisors keep notes in order to be able to refer to them in the next meeting and to provide records of the direction service has taken.

The supervisory meetings are beneficial in other ways as well. Facts and ideas arise that may not be recorded anywhere else; these meetings are also occasions for applying theory to practice and determining the etiology of problems. Counselors receive guidance in organizational control of their caseloads, and the meetings may supply them with fresh perspectives on clients' situations and alternative approaches to try. The meetings are also occasions for deciding whether to continue or terminate particular cases. Time limits are set for termination or length of continuing service.

A similar review and assessment occurs in the counselor workshops which meet once a week or biweekly, but while the supervisory sessions focus on a review of each team's total caseload, group sessions focus intensively on two or three clients of the total PACT inventory. The cases are selected on the basis of their having a current (or chronic) seemingly insoluble problem.

The Service Process

Goals and objectives were clearly stated in the original proposal for PACT, but the means to achieve them were expressed in more general terms. Consequently, the project has enjoyed considerable latitude in designing program service. PACT has taken advantage of this flexibility by sometimes modifying its service delivery to

correspond to emerging client and program needs. The project has left itself open to self-examination, and constructive change; thus PACT's service delivery has been dynamic and in some respects experimental, a phase that appears to be almost essential before a program enters into the period of stabilized methods required for research evaluation. The following description therefore attempts to portray the process of service rather than service as an unalterable product.

Referral and Eligibility of Clients

PACT referrals come from the Wayne County Department of Social Services (DSS) Foster Care and Protective Services units. As PACT gained recognition, referrals began to come in from other sources as well, such as the Public Health Department, local hospitals and clinics, placement agencies, mental health clinics, public schools, churches, and the juvenile court. This seems to be a result of PACT's close relationship with those community agencies and professional groups that are in a position to identify children's problems. Because of PACT's contract with DSS, all referrals have to involve a placement issue and have an open and active case in either Foster Care or Protective Services. Therefore, these units have remained the project's ultimate source of referrals.

To lay a foundation for the referral system, project leaders held several meetings with DSS supervisors and workers to explain and justify project eligibility criteria, build rapport and respect for the project's intentions, and work out referral procedures. An initial objection to referring cases was related to project eligibility criteria. The project was designed to treat home management problems, and unless a client was ready and able to benefit from this service, it seemed futile to accept the case. Without imposing stringent criteria, project leaders were concerned that referrals might be made which were unrelated to the skills and expertise of project personnel.

It soon became apparent to project leaders, however, that the "ideal" cases being sought were not often to be found among Foster Care and Protective Services clientele. Referrals were coming in too slowly and a decision had to be made either to let the project die in the obscurity of a miniscule caseload or to brace project personnel to treat hard-core cases. The latter course was chosen, and in order to improve the flow of referrals the project modified some of its criteria.

For some the modification has obfuscated the select purpose of project service, confusing it with the role of the social worker. However, the project maintains that its paramount emphasis has been on developing home management skills. But instead of clients enrolling with a readiness to learn these skills, the project has frequently had to bring clients to that point where they are able to concentrate on these skills. Evaluation will tell whether the modification of eligibility criteria negatively affected the attainment of project goals.

Upon careful study of a family's individual circumstances, the eligibility criteria are applied to determine if the case has been appropriately referred. In general, families with problems such as money management, ineffective coping techniques, inadequate disciplinary control of children, a chaotic physical environment, or neglect of parental responsibilities have benefited most from PACT's services. Some basic criteria are applied routinely; others are applied flexibly, depending on the particular family problems and strengths. These basic criteria are:

1. The family must be part of the active caseload of the Wayne County Department of Social Services Foster Care and/or Protective Services units.

2. The child(ren) must be at risk of placement or about to return from placement.
3. The parents must want the child(ren) back from foster care or not want the child(ren) placed.

The flexible criteria include:

1. Parents who are drug addicts or alcoholics will be accepted if they are successfully rehabilitated or enrolled in a rehabilitation program.
2. Acceptance is questionable if there is a violent individual in the home.
3. When identifiable, cases involving severe sadistic abuse will not be accepted.
4. Parents with a chronic psychosis or severe mental retardation are generally not accepted.

The Intake Process

Intake begins when a worker from another agency makes a referral, by either phone or mail. Intake is completed when, after an initial visit, the family is enrolled in the program.

Once a referral is received, several steps are taken prior to the initial visit. The project casework supervisor obtains the most thorough history available from the DSS referring worker. Next, each case is assessed in relation to the eligibility criteria outlined above. Upon establishing that the family meets the project's initial requirements, the casework supervisor arranges to review the case file with the referring worker in order to obtain the additional background which is often needed to understand the family situation and further evaluate the need for service. The review includes a written assessment of the family's needs, with consideration of social, psychological, medical, and developmental factors. Based on this information and input from the referring worker, a tentative treatment plan is developed delineating short- and long-term goals. This joint formulation of goals helps to coordinate the efforts of PACT, DSS, and other agencies involved with the family.

Following this preliminary review and assessment, the casework supervisor, in consultation with the director, determines the family's eligibility for service. If the family is rejected, a letter is sent to the referring agency indicating the reasons for rejection. If the family is accepted, an acceptance letter is sent to the referring agency along with the names of the PACT counselors who have been assigned to the family. Families and counselors are matched as closely as possible on the basis of the counselors' current caseload, their own characteristics, skills, and strengths, and the characteristics and geographic location of the family.

After some discussion of the case, during which immediate plans are outlined, an initial visit is scheduled by one of the counselor team members. The visit itself is conducted by the director or casework supervisor and one of the team members, and is meant to provide the basis for an informal assessment of the client's internal and external environment and its conduciveness to the promotion of the client's and family's welfare; the client's skill level and motivation; client-child(ren) interaction; the client's and child(ren)'s health and development; the client's use of community resources; and any obstacles to the performance of service.

The visit is also meant to inform the client regarding the nature of project service, the depth and conditions of client involvement, and the voluntary and confidential nature of involvement. The project makes every effort to determine a client's eligibility for service before the initial visit is made. However, it sometimes happens that a refusal of service has
28 to be made during the visit. In such cases, the director or casework supervisor explains that

the service is not appropriate for the client's needs and that efforts will be taken to locate the needed service.

Once the project personnel and client agree on the enrollment, a consent form is read to the client, who is then asked to sign it. Project personnel strongly stress that the service process is a pact between counselors and clients. Certain parts of service are mandatory, such as keeping appointments, working out verbal or written contracts, following through on agreed-upon plans, attending parent workshops (unless the client has a reasonable excuse for nonattendance, such as a regular job), and agreeing to formal observations and interviews of client and child(ren). However, clients' own perceptions of their needs are always considered, and it is by means of collaboration and cooperation between clients and counselors that the goals of service will be achieved. PACT therefore seeks a firm commitment of cooperation from the client at the outset, stressing that the enrollment is voluntary, and the client should sign up only if ready to make this commitment. The project is not out to gain members, but to help improve the lives of its clients; only through their continuing cooperation can this be accomplished. Furthermore, the client must understand that he or she may quit the project at any time without such a decision affecting the services received from DSS.

PACT's involvement in cases that might at any point lead to placement or permanent custody of one or more children carries with it the responsibility to discuss that fact openly from the start. The client needs to be told that a lack of progress after a limited time would have to be reported to DSS and, if necessary, to the juvenile court, because this information might best serve the interests of the client and child.

In order to obtain as much information as possible at the beginning of service, project personnel ask the client to sign medical, psychological, and school release forms for those family members who, according to the social service record, have had problems in any of these areas. When it is sensed that such a request might be intimidating and therefore premature, this part of the initial visit is postponed until the counselors have gained the client's trust.

Development of a Treatment Plan

Referral and the intake process are only the first steps in the development of the individualized treatment plan that will best serve the new client's needs. In order to be workable and effective, such a treatment plan must be founded in:

1. a cooperative counselor-client relationship
2. a relevant knowledge base, including as comprehensive a picture as possible of the client's background, current situation, strengths, weaknesses, and attitudes
3. organized planning from the start
4. the availability of a variety of resources
5. a beneficial relationship to other services and agencies

The Counselor-Client Relationship

A cooperative and trusting relationship with the client is an essential precursor of successful service. Although the establishment of the relationship and the commencement of service may overlap—as in the case of meeting the client's material needs, a potential reinforcement of the relationship—no substantial progress is made unless the counselor's perception of the need for change agrees with that of the client. This does not mean that the counselor adopts on first sight the client's version of needs, but that together they sort

out and identify problems and service needs. This sorting process is the beginning of the relationship. Both counselors and clients have constraints in reaching this point.

Faced with a multitude of problems, a substantial number of clients are bewildered and overwhelmed, and have lost or never had a sense of where to begin. Their responses often are infantile and emanate from a gross lack of experience in mastering the tasks and problems of living. Basic distrust, the crystallized residue of prior betrayals by parents, is translated into varying degrees of suspiciousness and withdrawal. Clients may either fantasize a way out of the morass or deny entirely the existence of problems, proceeding to exist on a day-to-day bare survival basis, never enacting a short- or long-term plan.

Attention must be paid to the client's dependency needs. Many of PACT's clients have experienced massive deprivation in childhood, and the emptiness this left them has never been filled. Other clients have recently lost someone close to them. In both cases it is almost essential for them to live through a period of dependency in order to gain the resolve to function productively. Temporary dependence on the counselors gives them someone to fill the gaps of isolation so that the world becomes a friendlier place, and hopefully someone with whom to identify. Identification is essential if the client is going to want to continue seeing and to please the counselor by fulfilling requirements. It is also essential if the client is going to view the counselor as someone to model after in meeting the needs of the children.

In beginning a relationship with a client, the counselor is in a sense burdened with a "change" point of view. Unlike the mental health professional, the counselor lacks the leisure to let the story unfold. Time and service constraints force action. Yet a large measure of the mental health professional's kind of respect for the client's perception of the problem goes into building the counselor-client relationship. Consequently the PACT counselor walks a tightrope between the role of the accepting mental health figure and the change activator. Such a tenuous balance necessitates a thorough examination of the criteria for change in relation to service and time limits. What needs to be changed and what doesn't? What changes are possible or probable? Is the counselor's perception of the need for change in reality biased, and the change unnecessary? Can the change be expected within a limited time? Is it related to service goals? Answers to all of these questions are preliminaries to commencing service.

During the first month of client contact, counselors work toward laying the foundation for this relationship in preparation for designing the treatment plan. The counselors convincingly convey to the client that he or she and the family are valuable, and establish rapport with the client. Accomplishment of these objectives, although often superficial in the early stages of service, at least provides the groundwork for the project and client to proceed cooperatively. The project deliberately avoids second-guessing client sincerity at this stage. An optimistic posture toward the client's interest in progressing is essential. Skepticism, while present, is held in check.

To give weight to the counselors' efforts toward establishing a relationship with the client, the project freely employs auxiliary services such as donations, home repairs, and housing search. The objective is to offer tangible services whose benefit can be immediately felt by the client. If the client is at first resistant, these services can often be accomplished despite a lack of cooperation. Yet they concretely tell the client that the project means to help. Where there is more client cooperation, other services may also be initiated from the start.

Client participation in parent workshops is also helpful in establishing trust in the
30 project as a whole and the counselors in particular. There, clients meet peers who may be

farther along in project service and have come to consider project personnel as allies. Provided the particular workshop is still in a formative stage, older members often extend a warm and generous welcome to the newcomers on behalf of PACT. Many clients convey the impression that they feel PACT is "their agency," almost akin to a large family. PACT's headquarters, an old, cozy brick and frame house on the Wayne State campus, adds to this feeling of closeness. In general, the sooner a counselor can bring a client to the PACT center the better. The physical environment and the informality and warmth of the PACT staff and clients help to dispel client resistance.

Throughout this first month's contact with the client, the counselors not only give needed service but elicit the client's view of what needs to be done. The counselors must listen, check out the client's meaning, and then listen again. If the client has trouble seeing where to begin, the counselors must help sort out the problems and break them down into digestible parts. In this way the counselors help the client establish the priorities of service, an essential step before a workable treatment plan can be designed. The ideal situation is where the client feels the treatment plan is of his or her making; PACT is simply the facilitator.

A Relevant Knowledge Base

Because PACT's orientation is toward the disciplines of child development and family relations, counselors and supervisors are attuned to the presence or absence of factors that contribute to positive family living and the optimal development of children. Considered in an ecological context, these factors are many: income and management of financial resources in relation to providing for family's physical, personal and social needs; the specific nature of parent/child interaction; child discipline and expectations; observations of the presence or absence of early bonding and attachment; parent's and child's cognitive, psycho-social and physical development; parent's home management skills; safety, organization, cleanliness and aesthetic qualities of external and internal environment; family's health, hygiene and nutrition practices; family's utilization of personal, social and community resources. Such classifications provide structure for observations and assessments of the parent's and child(ren)'s behavior and total environment in relation to that behavior.

Needs assessment is best completed by PACT workers with specialized academic preparation and training, hence the need for professionals in child development and family relations. Out of this background counselors are able to assess with assurance the interelationship of various factors and their relationship to the total development of child(ren).

In addition to the home assessment, specified target children are brought into the office for more formalized observations and screening assessments. When developmental or psychological problems are identified in the screening, PACT makes arrangements for more rigorous assessments and evaluations. Herein lies an advantage of PACT's affiliation with the Family and Consumer Resources Department and the university, in general, from which professional input and evaluations are available.

Guidelines that are used by counselors in assessing the needs of clients and their families may be found in Appendices (Needs Assessment). Assessment is continually refined throughout the first four weeks of service with problems and their sources gradually being accurately identified. As can be seen, the needs assessment requires a categorization of the family situation. Unless approached in this structured manner, the endless number of factors which often impinge on family functioning may be diffused in a welter of odds and ends. Following is an example of a few categories of a completed assessment:

Financial: Mrs. Brown is presently receiving ADC for herself and children. Poor money management and an accumulation of back bills have created a severe problem for the family, causing utility shut-offs, poor nourishment, and a generally unhealthy, inadequate environment.

Environment: The Brown home is in very poor condition. The structure is in need of immediate repair; the plumbing is very bad and leaking to the extent of destroying areas of plaster ceiling; the toilet cannot be properly flushed; faucets in the kitchen are not working; a new hot water heater is needed; the furnace has needed repair for two years; windows are broken; the front storm door is a frame only and the main door has no door handle or lock. The home is always dark, very dirty, cluttered, and sparsely furnished. Very little pride or care is shown at all in these surroundings.

Development of Children: The educational development of these children has been severely impeded by their lack of attendance at school. The mother has been keeping the children at home for a variety of reasons over the past two years. This has caused a severe inappropriate grade to age level discrepancy. The children are often sickly, seemingly due to lack of heat and other facilities in the home. Although there seems to be a strong emotional tie between the mother and children, there is much evidence of a lack of stimulation and proper developmental encouragement of the children. The older children in the family have dropped out of school completely and show no signs of personal motivation to acquire employment or further their skills or education. One daughter in the home—Ruth, who is also the mother of Mary—seems to ignore her responsibility for parental interaction with this child. Ruth is also pregnant. The older children are apparently not involved in helping to maintain the home in any way.

Parent-child Interaction: Other than an apparent show of concern and an emotional bond between the mother and her children, other levels of interaction between the mother and children seem very minimal. Verbal exchange often involves quick directions that seem most often to be ignored, especially by the older children. In the case of the teenage and older daughters, there seems to be no control exerted by the mother. There also seems to be much social disorganization in the home, with the mother unaware of where each child is at all times. When the children are around the mother, however, there is a definite show of attachment and concern for her. Recreation for the children and home stimulation is minimal. However, George and Michael make constant use of a boxing and basketball club close by. Mrs. Brown frequently speaks of visiting John at the Training Home and states she is anxious for his return home.

Nutrition: During discussions with the mother, her statements indicate an adequate knowledge of proper nutrition for her family. It seems, however, from observing other family habits and from statements made by the children that the family does not practice sound nutritional habits. This may in part be due to the inadequate facilities in the kitchen area and poor budgeting skills. The only table in the downstairs area of the home is located in a dark corner, and is usually a catchall for clothing and other paraphernalia. There is no centralized eating table area for family meals.

PACT Counselors: S. Meagher
D. Miller

During the period of assessment the counselor fills out an evaluation form; sample form
32 may be found in Appendices (Initial Visit Form).

Organized Planning

Approximately one month after the initial visit, a treatment plan is formulated. By this time a great deal of knowledge and understanding of the client's situation has been gained. Naturally, service to the client occurs before this date; crises occur, and obvious needs that can readily be served by the project cannot be ignored. But a month gives the supervisor and counselor a chance to ascertain patterns of insufficiency and design treatment accordingly.

An effective treatment plan has its own integrity: its parts are congruent and internally rewarding in a way that continually fosters positive growth. To impart this integrity to the treatment plan, the counselor has to have absorbed and assimilated the client's total situation while maintaining an objective stance. The more that is known regarding client problems and strengths in relation to service goals, the greater the likelihood of designing a treatment plan which the client feels makes sense. Accurate meshing of needs and service supplies the internal rewards that foster change. Nevertheless, internal rewards alone are often not enough to sustain the momentum of positive change. They must be supplemented with many external rewards, such as praise and desired material goods. Conversely, external rewards alone would not be enough to sustain change, a primary function of an intrinsic reward system.

Problems are classified in relation to each category of project service, along with who has the problem, its possible etiology (e.g., mother abused as a child; lack of persistence in obtaining financial support; development lag due to lack of stimulation) the specific strengths of the client or family member potentially conducive to treating the problem, the objective of treatment, the overall goal served, who will carry out treatment, and an anticipated time period for treatment. This treatment plan, along with a covering data sheet, duplicates as a work plan for the counselor and an initial monthly report for the referring DSS worker. Each succeeding month's accomplishments are added to the original or, if necessary, altered plan. It is this comprehensive and interconnected picture of the client situation that functions as the blueprint for service. Once a relationship has been established and the assessment and treatment plan completed, the time has come to develop a contract with the client—the first step toward implementing the treatment plan.

Gwen Brown enrolled in the Parents and Children Together Project on June 12, 1978. She and her PACT counselors, Nancy S. and Colleen S., have together discussed and assessed the home management areas of the client's situation which need attention, and agreed to the following plan:

To improve the developmental status of John, 2, and Amy, 3:

1. Starting June 26, 1978 Ms. Brown agrees to attend PACT's parent workshops weekly to learn more about parenting. At the end of an eight-week session Ms. Brown will receive a certificate.
2. PACT counselors will visit Ms. Brown two times a week for the next two months to teach and model positive interaction between Ms. Brown and her children, work out acceptable methods of discipline, and provide or help locate educational play materials for the children.

To improve Ms. Brown's money management skills:

1. Counselors and Ms. Brown will draw up a monthly budget and together evaluate weekly adherence to the budget.
2. For the next month Ms. Brown agrees to inform the counselors when her check and food stamps arrive every two weeks. Then together they

will go on shopping trips for food and other items so that the counselors may instruct Ms. Brown in economical buying practices.

3. Ms. Brown agrees to pay $20 a month to the gas company starting with the next check until she has paid off an overdue bill of $60.
4. Ms. Brown will avoid spending money on pop and chips at the corner grocery store.
5. Counselors will immediately assist Ms. Brown in signing up for the Focus Hope supplemental food program.

To develop a clean and organized environment which is efficient, stimulating, and rewarding for all family members:

1. Ms. Brown agrees to have her brother and her son, Charles, 16, paint the living room.
2. PACT will supply the paint in time for the job to begin August 1, 1978.
3. Starting August 1 Ms. Brown and the counselors will set up charts for the children to follow for doing household chores, such as picking up and straightening their rooms, doing the dishes after the evening meal, scrubbing the kitchen floor, sweeping in the rest of the house. The children will receive small rewards from the counselors for their satisfactory completion of tasks.
4. Ms. Brown will monitor the charts and let counselors know the results on a weekly basis so that the children may be rewarded.
5. Within the next two weeks PACT donations will deliver a stove, two beds, and mattresses for the children, and other needed household items as they become available.
6. PACT home repairs will replace broken windows. Charles and Stewart will help the home repair crew.

Time limit: The above goals and plans will be completed in three months from August 1, 1978. Progress of Ms. Brown will be evaluated overall each month, with changes being made when necessary.

_____
Client

_____
Counselor

_____
Counselor

_____
Date Signed

Clients sometimes reach the point where they proudly greet the counselors with the tasks they have accomplished since the last visit and then ask, "And what have *you* done?" They realistically see themselves as one of a team with the counselors in working on the problem.

Availability of Resources

In developing the treatment plan, the supervisors and counselors adhere to specific treatment. This often involves treating tangible obstacles to growth while or before proceeding to a less tangible level of service. For example, PACT might settle rent debts before attempting to improve family interaction patterns. PACT maintains a variety of service
34 components intended to meet recurring client needs which have not been covered by

other available resources. These internal services are supplemented whenever necessary with resources from throughout Wayne County.

Care is taken in selecting the resources so that the composite treatment plan meshes with the specific needs of the client and family. When the client is referred for services outside the project, the counselor has the responsibility of seeing that the client or appropriate family member actually enrolls in and continues to receive the service. Release forms are routinely requested from the client in order to obtain reports on client progress from outside agencies.

An additional resource stems from the fact that PACT's budget includes funds to purchase directly services or goods critically needed by families. When PACT initiates service to a family, an account or fund is established that the counselors involved can draw on for a variety of reasons. In order to maintain control over this large fund, PACT has broken it down into accounts of $150.00 for each individual family. Counselors have the responsibility of budgeting these accounts for the families in their caseloads and must approve all expenditures. Expenditures over $25.00 have to be approved by supervisors. The funds are used to purchase emergency child care, emergency household equipment, educational toys and materials, extraordinary health supplies, small rewards for families, and bus tickets.

> One family of sixteen had real difficulties organizing the children to assist in the overwhelming amount of housekeeping chores. We first set up a "family council meeting" in which the problem was explained. The family discussed and divided up a list of chores the mother had written and a schedule was set up for getting them done. We then encouraged the mother to set up a chart and put stars on it when the children accomplished their share of chores on time.
>
> During the discussions with the mother concerning the difficulties in keeping up such a large family, we found that much of her problem with clean clothing and laundry centered around a lack of storage space. There was no place for soiled clothing and articles. She also felt there was a terrible problem with the children being able to keep their belongings and toys together. Again, with so many in the home, storage seemed to be a real problem. "And the dishes," she sighed, "—we just don't have enough to go around! It takes so many plates and glasses and forks and spoons. We have to eat in shifts and it makes dishwashing such a problem. I wish we could just all sit down together like my family used to do! You know, you can talk then and enjoy each other."
>
> Because we knew we had a fund to work with, we asked her if she thought it would help if she used different colored laundry baskets in the rooms for soiled articles. That way the children could help carry down the laundry also. Then we suggested some large plastic containers like a kitchen-size trash basket in bright colors for each child's treasures and toys. She really seemed to like the idea and added some insights as to how she could use them. Then we asked if it would be helpful to her if we could get some dishes and silverware, and she seemed very pleased. We promised to return the next day.
>
> By now, we know the bargain shops and stores with industrial and restaurant supplies, and we keep finding more. We were able to get all the baskets, containers, and dinnerware before the next afternoon and brought them over. The mother was delighted. She had already started cleaning and sorting things in the bedrooms to give the children a good start. The baskets and containers and dinnerware provided a terrific incentive . . . to organize her large family.
>
> The next week, we checked on who was getting stars and rewarded an older

daughter with some cologne and a younger son with a little puzzle, but what we stressed was their pride in themselves for having been such an important part of making their home so much nicer for them to live in.

The money we had available to us to assist the family with this enormous task provided the extra incentive, some rewards, and the actual items necessary to get the whole program off to a good start.

D. Miller

Beneficial Relationship to Other Services and Agencies

Department of Social Services: PACT's work proceeds within the framework of a larger, supportive relationship with the Department of Social Services. Counselors are required to maintain consistent contact with the referring DSS worker, since it is this worker who has the authority to recommend the return or placement of the children. This relationship between DSS and PACT is an advantage to counselors in dealing with the client. For example, when progress is being made with the client, the DSS worker's influence may be utilized to clear the way for obtaining certain needed services from the department, such as furniture orders, early preparation of an Aid to Dependent Children application in anticipation of the child(ren)'s return, or a speed-up in the hearing date so that the child(ren) may be returned sooner than a statutory hearing would provide. The counselors seek to impress the client with the positive effects that might occur as a result of client progress.

On the other hand, the authority of the DSS worker is presented matter-of-factly to the client who is not progressing: "If you don't apply for general assistance and work with us toward finding a better home, you will force us to report your lack of progress to DSS, and your son's return may be delayed." In particularly resistant clients, the DSS worker may be asked personally to add weight to this point. This action is not to be construed as threatening the client, but rather as realistically pointing out the relationship between cause and effect. For the counselor to ignore this relationship would be a disservice to the client. Continually impressing the client with cause-and-effect relationships also helps to foster client acceptance of personal responsibility for actions. If the client can develop the habit of weighing possible consequences, then positive rather than negative or no action might be the result.

Frequently PACT counselors must also seek the cooperation of DSS Assistance Payment workers. Unlike the relationship with referring workers, procedures have not been formalized for regular collaboration. Cooperation is not uniform, with the result that financial problems become one of the knottiest obstacles to client progress. This is severely aggravating and depressing to the affected clients and constitutes a wasteful use of the project's service.

In many cases, PACT's efforts to stabilize a family situation are hindered by the delay that often occurs between a family's application for Aid to Dependent Children benefits and the time they receive their first check.

In one of my cases this delay stretched into several months. The client, Camille, had four children to feed, shelter, and clothe. During the wait for her case to be opened she was given a food order of $61.60 every two weeks. This wasn't even enough to feed the family, let alone meet their other needs. When we got involved in the case the client had already been waiting two months and we figured it would only be a short time before the checks started. We supported Camille with donations of clothes and furniture and provided her with transportation.

36

After two more months passed without a check, we realized that the situation was deteriorating. Without an increase in income to an adequate amount this family would no longer be able to function. The upper flat they lived in was in disrepair, there was water in the basement, no heat, and the lower flat had been burned out. The landlord would not make repairs since our client was unable to pay the rent.

In addition, Camille was becoming more depressed and frustrated at being unable to care for her children properly. She tried to find out the reason for the check's delay by talking to her Assistance Payments worker, the supervisor, and even the manager of the district office. We spoke to these people as well, but kept getting the same answer—the case had to go through several channels and the office was backed up with work.

Camille finally became so depressed that she left the children with a young cousin and took off for several days. We realized that she was depressed and that something had to be done before her children were removed for neglect.

We convinced Camille to return to her children, and for extra support had her move in with her half-sister for a while. Then we went to work on getting the ADC case opened. We talked to her AP worker's supervisor, but got nowhere. After talking to our supervisor, we decided to call the Department of Social Services' Community Affairs office and put in a complaint. Within two weeks' time, Camille was informed that her case was open. She received her first check a week later, six months after she had first applied for aid.

The long ADC delay almost resulted in tragedy for this family, but we learned an important lesson. Faced with the same situation again, we'll know how and where to get results, and the next family might not have to suffer so much.

D. Kade

In addition, PACT maintains cooperative relationships with a number of institutions and community agencies. These include the juvenile courts, the public schools, medical and mental health clinics, childcare centers, placement services, and supplemental food programs. While relationships with these resources are mutually beneficial, PACT has found certain inequities that need to be addressed. The following focuses on the juvenile court and the school system.

The Juvenile Court. In an unknown number of abuse and neglect cases where change in custody is at issue, decisions are made which do not accurately reflect the circumstances of the cases. A lack of accurate facts may make it impossible to ascertain how best to serve the child's interests.

PACT counselors are charged with the responsibility of systematically documenting all that is observed and discussed in relation to their intervention in families. From the beginning of service, PACT discloses to the client that this is being done, and that their permission to share such information with the court is part of the voluntary agreement to enroll in PACT. This documentation is intended to be an important part of the grist for court decisions affecting placement status, and is conveyed to the referring DSS worker as part of the agency relationship to the department. In addition, PACT counselors actually present appropriate documentation of cases in court.

Because of the intensive nature of PACT's work with clients, and the agency's child/parent orientation and expertise, the counselors are well equipped to provide relevant factual accounts of family circumstances. Nevertheless, discrepancies between court decisions and family circumstances persist even in some of those cases where PACT is involved.

One part of the problem seems to be connected with the matter of counsel for all

litigants. State of Michigan juvenile code provides for separate counsel for parents and the child at the preliminary hearing. While such counsel may be supplied by the court, however, investigations independent of the DSS record, and contact with clients prior to the day of hearings, are rare. The code does not provide counsel for subsequent supplementary dispositional or statutory hearings.

Theoretically DSS may be represented by the Attorney General's Office as is provided under State law for all State governmental bodies. But the burden of representing DSS in all child abuse and neglect cases would be phenomenal, and in fact such representation occurs in only a few, particularly severe, cases. The result is that a non-lawyer (the DSS worker) is required to prepare complaints and petitions in most cases, present evidence in court, and also document the allegations. Several objections can be made to this procedure: If an investigation were made within an appropriate legal framework the case might never have to be brought to court; legal input in the investigation at the outset would assure more appropriate initial placements of the child(ren); legal input along the way at subsequent hearings would shorten the term of placement, speed up the court process and assure the attainment of permanent placement decisions, either in the natural home or in adoptive settings if warranted. At subsequent hearings the worker who seeks a permanent placement outside the natural home hardly has a chance against the seasoned attorney who might be representing the parent. A severe injustice might therefore be done to the child(ren).

The Schools. For many client/families, PACT has been called upon to act as advocate in the school system. In fulfilling this role, PACT has found that there are three general types of school problems that characterize the client population:

1. The school-age child has a learning disability that requires placement for specialized learning techniques. The road to securing these placements is not always readily apparent to someone unfamiliar with the internal workings of the school system. Finding out the kinds of programs which might be available to the child requires assertive and persistent effort, qualities which often have not been developed in the parent population. A referral must be made by the school principal and/or teacher and the parent (usually to the region psychologist), a psychological evaluation of the child must be secured, and a planning and placement meeting arranged of parent, region psychologist, and others concerned. If the psychologial evaluation is completed by a private source, there may be confusion as to the recommendation since the school has a special terminology for requesting particular placements. Because long delays in securing an evaluation appointment from the school system may render the whole issue irrelevant, the task of coordinating school and individual terminology becomes another important step in the placement process. Because the parent often lacks knowledge about the range of placement possibilities available, the school board generally maintains control over the selection of placement and requests the parent's concurrence. The parent may ask for another meeting to change the placement if it is inadequate, but meanwhile time important to the child's appropriate development has passed by. The placement itself for learning disabilities may amount to specialized instruction once every two weeks and consequently meet the legal mandate in only a token way.
2. Although abundant programs exist for the mentally retarded school-age child and ancillary programs for the non-retarded parents of these children, to PACT's

knowledge there is no program to train mentally retarded adults in the care and parenting of their mentally retarded children. Yet PACT has seen many such cases.

3. Far more frequent than the foregoing are cases involving the child who has frequently been truant from school or who has suffered long-term illness and consequently dropped below grade-level. Specialized education for learning disabilities and retardation have been mandated by the State, but to PACT's knowledge there is no mandate requiring remedial education. The alternatives are few: the child may be placed in a classroom for slow learners although this is not the problem, placed in a class below grade level, or if old enough, apply for Graduate Equivalency Degree classes. The older child often elects to save face by staying home from school or playing hookie rather than be branded a dummy or attend classes where the children are much younger and smaller. His/her education often is obtained on the "street."

Combined Individualized and Theoretical Approach

Staff contact with the client is in the spirit of friendship and moral support. Frequent and consistent visits, plus material services and the accomplishment of goals, promote the development of this relationship. However, the counselors must constantly be aware of themselves as models and teachers.

While occurring in the context of a supportive relationship, PACT's approach to service has a theoretical and educational basis. The approaches most basic to project philosophy are the counseling approach, modeling and demonstration, and reeducation. In tune with project flexibility at this stage and with the variety of needs to be met, counselors utilize many other approaches. These may or may not have mutuality with the basic approaches. They include problem solving, behavior modification, role playing, confrontation, and coercive persuasion.

The Counseling Approach

The counseling approach involves mutual identification of a problem, listening and accepting the client's expression of feeling, giving reassurance, and building self-confidence and motivation to take action on the problem. This approach is the basic theme of the relationship between the counselor and the client, which has already been described.

Modeling and Demonstration

In modeling and demonstration the counselor focuses on his/her own behavior in setting a model for the client. The counselor encourages positive identification with him/herself while a specific behavior is being modeled and demonstrated, so that the client will be helped in adopting the behavior.

> Modeling is one of the techniques that we use with the families and it is sometimes more effective than just talking or suggesting ideas directly to the parents and the children. A modeling experience is illustrated in the following case.
>
> Martha is fifty years old. She is the guardian of six children from six years to thirteen. The father of the children, William, a middle-aged man, lives with them and helps Martha to raise the children. While the children lived with their natural mother they experienced a chaotic life that is still reflected in their behavior at home and school. Our visits to the family consist mostly of group sessions where we have the opportunity to interact with Martha, William, and the children at the

same time. The purpose of our last visit was to suggest to Martha that the children should have scheduled time for doing homework and that they may need some help with it. It took only a few minutes to explain this idea. We waited for the children to come from school and modeled for Martha how to handle the homework time. We modeled for the children how to help each other. First we talked with the children for approximately fifteen minutes about school, their friends, and the fun and frustrations of the day. Four of the children had homework, and we initiated their study by looking at the schoolwork. Everyone needed help because they are behind in classes. The two older girls, Tania and Celine, were laughing at their brothers for the mistakes they made in math. We used statements such as this: "There is nothing wrong in making mistakes," and "Because we don't know everything—that is why we go to school: to learn." We asked Tania and Celine to help their younger sister to correct her homework. They did it. We interceded in order to stop fighting over pencils and for the places close to us, etc. We sometimes sent the children to show their work to Martha, and she ended up helping us.

For one hour we modeled, giving Martha and the children a chance to accomplish an activity, to learn an effective method of dealing with homework, and to build a close relationship between the children and Martha and between us and the family.

R. Pardo

Out of positive feelings for the counselor, the client identifies with him/her, and gradually begins to imitate the behavior. The modeling and demonstration approach is particularly effective in teaching appropriate child disciplinary techniques and parent/child interaction. For example:

The two-year-old daughter sits on the floor rocking and sucking her thumb. The mother shouts, "Tina, get that thumb out of your mouth before I wallop you." Seizing the opportunity, the counselor takes a wooden pull-toy out of her purse (one she intends to leave in the home). Getting down on the floor beside the child, she shows her the toy and asks if she knows what it is, "It goes woof-woof; do you know what goes woof-woof? Do you think it might be a dog?" "Doggie," says the child, now ceasing her rocking and somewhat interested in the toy. Putting the toy on the floor between them, the counselor asks, "Would you like to see the doggie go?" She pulls the toy gently a foot or two. The child takes her thumb out of her mouth, and reaches for the toy. She turns it around and around in her hands, then slams it on the floor. The mother starts to yell at her, but the counselor softly intercepts, "Can you be gentle with the doggie? Here, may I show you how he goes?" She gets up and pulls the toy around the room. The little girl laughs delightedly, jumps up, and takes the string from the counselor.

Thus the counselor manages to combine a demonstration in child discipline, stimulation, and interaction with the child.

Reeducation

The reeducative approach is used when counselors instruct the client or family member in how to perform certain tasks. The task is taught step-by-step and often modeled and demonstrated at the same time. Some of the tasks seem so basic that no adult ought to need to learn them, but the fact is that some clients have never been taught how to organize a house cleaning, prepare a balanced meal, shop economically, make out a

budget, bathe the children, catch the bus to a certain destination, repair a leaky faucet, redecorate a room, or organize storage and living space.

Problem-solving is similar to the counseling approach with the difference that the former is more directive. The counselor helps the client identify the problem, gather information in relation to the problem, figure out what the causes are, identify possible solutions, decide on the best solution, carry it out and evaluate the result. *Behavior modification* involves the use of reinforcement to correct discrete problem situations. The approach is most effective when the problem situation is broken down into small parts. For example, the child whose room is constantly in disorder would be rewarded for consistently putting his dirty shirts in the hamper, and then for also putting his socks in the hamper, etc.

Role playing is a form of modeling and demonstration which the project has found is an effective learning tool in group sessions such as the parent workshops. For example, in the case of a client who feels anxious about appearances in juvenile court or at case conferences, role playing the situation before it occurs helps to allay anxieties by giving the client a prior understanding of the way the whole event is carried out and the role the client will have in the proceedings. The value of role playing, if done effectively lies in the opportunity it gives participants to play out a situation and experience the thoughts and reactions generated by the associated interaction without the stress and anxiety of reality. The ensuing discussion of these feelings and responses helps to clarify and redirect futile reactions.

> An issue that has come up often is that of money: "If I had money I'd have no problems." We dealt with this today via "family sculpture" with group members taking the part of "a rich Bloomfield Hills family." Mother was bored, had nothing to do, and drank. Father was not interested in being home and seldom was. Sister was on drugs and Brother had so much pressure to live up to his parents' expectations that he'd left home and was off "doing his thing." The point of this scene was well taken, and a short, lively discussion followed.
>
> Robin and I then did a role-playing situation of a mother who has company and the child keeps interrupting (she ignores, handles, and attacks the child). This proved to be something with which everyone identified and a good discussion followed.
>
> Robin then did a different form of role-playing where she said she was an expectant mother (4 months pregnant) who had chosen not to have an abortion though she did the last time. She still has doubts about having the baby, what it'll do to her freedom ("You can leave them alone at 8 or 9 years, can't you?"), and what it's like to be a mother. We went around the room and each of us had a chance to tell her own thoughts and feelings. A few were: "Are you sure you want the baby? They get on your nerves." "It's no problem if you have money" In an outraged voice: "You can't leave an 8 or 9-year-old alone." "Children are a joy."

Acting out "child discipline" techniques or parent-child interaction also lends itself to role-playing.

> The mother was enraged at her 12-year-old daughter who had just been dragged into an alley and accosted by a 16-year-old neighborhood boy. The daughter also had a history of being raped. I asked the mother to pretend she was the daughter and I was the mother.

Confrontation combines elements of many approaches. It is given separate identity in order to emphasize the confrontative counselor's change in attitude. In cases where the client continually neglects certain tasks essential to the child's welfare, or there is a complete lack of progress, the counselor becomes more assertive and direct, stressing the relationship between cause and effect: "If you do not move to suitable housing, the court will not return your child." The counselor tries to secure a renewed commitment from the client at this point, and also sets a time limit of two or three weeks for further service, during which the client must show improvements or be dropped from the program. The following example illustrates such a confrontation.

> Ms. Dillard is a heavyset woman in her late 30s, with nine children; one is currently in a foster care home. Ms. Dillard is not married but is believed to have a man friend living with her and the children. The monthly income through ADC is estimated to be over $900. Yet there is no physical evidence of where the money is being spent.
>
> It has been very difficult for the PACT counselors to work with Ms. Dillard due to her lack of cooperation. There is no telephone in the home which adds to the difficulty of communicating and setting home visits. The few times the PACT counselors were able to meet with Ms. Dillard, her attitude was very genuine and warm. However, she would never follow through with recommendations and would continue to be absent from home for scheduled visits.
>
> Many approaches to this problem were implemented. The PACT counselors wrote her a letter informing her of the consequences of her actions. The counselors requested that the PACT director write her a letter informing her of the consequences of her actions. The counselors, along with the foster care worker for her son, met with Ms. Dillard in her home. They completely explained the PACT program to her and the necessity of her cooperation. Ms. Dillard agreed to cooperate but her word proved to be false.
>
> The PACT counselors were very discouraged and were saddened because they wanted to help the children. Unfortunately it is not possible to accomplish anything meaningful with the children if the mother is uncooperative.
>
> The PACT counselors decided to meet with Ms. Dillard once again. During this visit the counselors informed her that PACT would terminate in three weeks if she continued to be uncooperative. The counselors also informed her that they would have no choice but to recommend that her son remain permanently in foster care due to her lack of cooperation and poor environment.
>
> During this three-week period Ms. Dillard was in ill health often, but still made herself available to the PACT counselors. After her illness there was total cooperation. She began to attend the parent workshops, which she enjoyed immensely, and she began to improve her home environment. At her request the counselors planned visits to her son in foster care. This welcome cooperation from Ms. Dillard was long overdue. Both the PACT counselors and the foster care worker were very happy with the new developments and hope they continue.
>
> W. Council, Jr.

Coercive persuasion is simply a stronger version of confrontation. In this case, there may be resort to the use of authority. Coercive persuasion may be appropriate for cases in which clients are not capable of absorbing the full significance of their behavior (for example, mentally retarded clients or clients with characterological disorders):

Charles, 14, has a history of delinquent behavior, as do his brothers Daniel, 16, and Tony, 12. Charles spent a year in a home for boys and was returned to his mother last year. He enjoys coming to the PACT offices with his mother, and one day while visiting he managed to wander around with great freedom. The next day we learned that Bill, a fellow worker, was missing $60 from a briefcase he'd left in the upstairs office. The next day Charles came to the office showing off a brand new Panasonic casette recorder he said cost him $44. He also had some tapes and a new shirt. We came to realize that the only nonworker who had been roaming around was Charles. We explained the situation to his mother, Mrs. Wilson, and asked her to talk to her son about the tape recorder and his sudden wealth.

The following day Charles wasn't home during our home visit, and his mother said he'd told her he purchased the recorder for $25 with money he had just collected from his paper route. She expressed no doubts about his story, although we pointed our that the recorder cost more than $40 and he couldn't have made that much money overnight. We told her we were willing to check out his story to prove his innocence, or make him see the consequences of his actions and repay the money. We then located Charles at his school and pointed out the weak parts of his story. He finally admitted to taking the money, but with no trace of remorse or embarrassment. When we took him home, he assumed the role of victim and threw the tape recorder to us. His mother immediately jumped to his defense, accusing us of beating the confession out of him. We refused to take the recorder and again pointed out the contradictions in his story and our willingness to check it out, but Mrs. Wilson undermined our efforts by helping Charles challenge our accusations.

At this point our concern was not so much the theft itself as the mother's condoning the act. Her position was harming not only Charles but his brothers as well. Condoning the delinquent behavior of her children would not only continue but escalate that behavior. We asked the mother and son to reconsider their position and left. Our next plan was to see if we could interest a social-minded officer from the neighborhood police precinct in talking directly to Charles, but before doing that we let the situation rest for a day. The mother continued to insist that her son was being victimized, and she wouldn't press Charles to make restitution. We again asked her to reconsider and left.

Things were critical, and Mrs. Wilson understood this. She herself attempted to return the recorder to the store, but was unable to because the receipt was lost. Finally she agreed to give the recorder to Bill, the PACT counselor. We hope that the difficult decisions Ms. Wilson had to face have set a reference point for the future relationship between her and her children. Hopefully a bad situation was turned into a learning experience for mother and sons.

B. Lande

The counselors in this situation had to remind themselves constantly that for the sake of the children there was no alternative but to use an authoritarian approach.

Persistence in Difficult Cases

Whether intentionally or not, some clients tease the project's staff with a little progress here or there, but do not improve sufficiently to earn a return of children from foster care. Clients of this type seem to have developed strategies for manipulating the system which they maintain to the extreme of forgetting their original purpose in doing so. Manipulation has become a way of life. These cases are often so recalcitrant that it is impossible to break through the shell of resistance. Some progress may be made, but nothing enduring. On the other hand, the project does not mind being "used" by clients if

positive objectives may be attained. Manipulation of this kind may indicate that the client doesn't yet trust the counselors and other project staff and also senses that they have not really grasped the client's perception of his or her situation. Concerted efforts toward building trust and understanding the client may be indicated. But sometimes the best efforts do not work despite the counselors' ingenuity.

As a PACT counselor I remember one situation in particular to be extremely frustrating and difficult. The young mother we were visiting had given birth to a baby girl the month before. Before the birthdate our involvement with the mother had centered on her health and nutrition and preparing her for the newborn. Through donations we had also acquired some bedding, a layette, a playpen, and an old refrigerator that ran like a charm. During the visits we made in the weeks following the birth of her daughter, we became more and more disheartened as the mother became more disorganized and the home became increasingly unkempt and unsanitary. Each visit involved much modeling and demonstrating in basic childcare techniques. The mother was shown how to bathe, change, and care for the infant on several occasions when we discovered the infant had a severe diaper rash. The mother had stopped nursing her daughter and seemed to have little knowledge of the importance of proper preparation and refrigeration of the formula. We obtained an automatic bottle sterilizer, extra bottles, a bottle brush, caps, and nipples, and spent two lengthy sessions demonstrating the entire procedure, beginning with proper dishwashing techniques. We obtained the involvement of a public health nurse and on a third visit again stressed the importance of proper feeding and repeated the formula process. Our concern was growing. Although this situation may be understandable with a young mother and her first child, Sela was Eva's fifth child.

One day we arrived close to noon to find Eva on the front porch. She was surrounded by her four children, three school-aged cousins left in her care, her upstairs neighbor who was holding Sela, and the neighbor's three children. Eva was concerned about the fact that Sela had been crying so much the past few days. "She eats like a little pig," Eva stated, "and she still isn't satisfied. She's going to be a little fatty!" I've never seen a baby suck on things so furiously and get so angry at the pacifier!" verified her neighbor. "I know she is full enough when I feed her," Eva added, "because her little belly gets puffy—so I just don't give her any more." After asking Eva a lot of questions and checking Sela, we realized what was wrong. The infant was dehydrated and very hungry. When we asked if we could get a bottle and feed Sela, Eva said, "Yeah, it should be time. O.K."

When we went into the kitchen there was no food in sight, no dish soap, and all the dishes, pans, and utensils in the kitchen were soiled and piled in a heap in the sink. Roaches were everywhere and a single can of formula concentrate sitting on the counter was the only sign of nourishment for Sela. Eva walked to the dining room through the remnants of the school lunch program on the floor and removed the sterilizer from the easy chair in the living room. "I guess I better make her a bottle," she said. "I'm not used to all this, you know; my Daddy used to do it all."

I felt so angry that I wanted to scream at her. How could she treat these helpless children this way? Didn't she remember anything we tried to teach her? How could this mother, who had broken down and cried in court when it was suggested that the return of her four other children be delayed a few weeks, turn around and neglect them so? Instead we pulled ourselves together and went out and picked up some readymade formula and some dish soap. When we returned we had a long talk with Eva concerning her budgeting, feeding, and caring for her family, while Sela consumed 6½ oz. of lunch.

Eva and her children are now reunited with her family down south. The last report we received from that area indicates that Sela and the other children are in good hands.

D. Miller

Persistence in service and increased understanding of the client can finally result in a breakthrough. The key is to ferret out the underlying reasons for resistance and meet these with understanding if possible. The client is given credit for having reasons to resist that are not yet fully understood by the counselors and therefore impossible to judge. Different avenues for gaining understanding are tried. Often parents are not cooperative because they are confused about their true feelings towards the child and are unsure whether they want the child returned. This was the situation in the Smith family, although the PACT counselors did not understand that initially.

Ms. Smith had nine children, one of whom was in foster care. John was removed from the home because of severe neglect after having been taken to Children's Hospital for an illness. The hospital found that the child, aged twenty-two months, had cerebral palsy, was anemic, and had delayed physical growth. He had not been receiving proper medical attention and was placed into foster care after a month in the hospital. The case was referred to PACT shortly thereafter. The situation in the Smith home was still neglectful. The environment was poor, there was no heat, and children had no shoes and often went naked. Their mother seemed only vaguely aware of their needs and was delinquent in sending the children to school or getting them to the doctor when necessary.

Ms. Smith moved soon after, but the other conditions remained the same, and in addition she made herself unavailable to the counselors. She refused to keep her appointments with them, and even if she was home when they arrived, she would send a child to the door to tell them she was not there. After more than two months of this behavior, PACT counselor Rosaana Pardo decided a confrontation was necessary. The Protective Services worker accompanied PACT to the Smith home. Together they talked to Ms. Smith about her lack of cooperation and drew up a contract requiring her to visit her son at the Department of Social Services' office (which she had not been doing), to go to the clinic to observe his therapy, and to attend PACT workshops and cooperate with PACT. This approach failed, as Ms. Smith still refused to work with PACT.

Normally, under these circumstances PACT would consider terminating the case. However, Ms. Pardo felt that the children were receptive to her and decided to try one more time to reach Ms. Smith for their benefit. Ms. Pardo realized at this point that maybe Ms. Smith didn't want her son back. To confirm this, she asked Ms. Smith directly how she felt about John, and assured her that it was all right to express her true feelings. Ms. Smith admitted that she was confused and not sure if she wanted him back, considering his illness and the care involved if he were to return. She also said she felt relieved to be able to share her doubts with someone else. Ms. Pardo suggested that Ms. Smith talk to her other children and her boyfriend, who is John's father, about their feelings and come to a decision in two or three weeks, so that either a permanent placement or work toward a return could be started.

Two days later Ms. Smith called and told Ms. Pardo she had decided she wanted her son back and would cooperate with her. From that phone call on, Ms. Smith was a different person. She took more charge of her life and became open and friendly. She took all the children to the doctor and dentist, had them immu-

nized, got three of them much-needed eyeglasses, and took an active interest in their school progress. PACT provided furniture and clothes, which were eagerly accepted. The PACT worker and supervisors were amazed at the change. Best of all, Ms. Smith's attitude towards John changed. She began visiting him regularly and showed him much more affection than she ever had in the past. The other children began to visit John also, and all are eager to have him back again.

Brainstorming sessions with supervisors and other counselors help develop new perspectives on problems and new approaches to try. Nevertheless, if after three months exhaustive effort is in vain, a case is terminated with recommendations: referral for therapy, permanent custody or guardianship of children, suspension of service until the client demonstrates a readiness to cooperate, or whatever is appropriate. Most cases where the client is extremely resistant are characterized by a history of chronic pathology: severely disturbed personality, drug or alcohol abuse, or characterological disorders.

Case Continuation

If a case has passed the three-month threshold and progress is continuing, a deadline for continuing services is established according to the following criteria:

1. If a child has just returned from placement, service will continue at least for a month, depending on family circumstances.
2. If a child is in placement but a court date is scheduled at which a decision to return is likely, service will continue at least a month beyond the court date, and longer if return is delayed.
3. If certain issues regarding a child in danger of placement at the beginning of services are still not entirely resolved because of external circumstances (for example, if it is summer and schools are closed), service will continue for a reasonable period to accommodate these circumstances. If such circumstances will persist for more than three months and other problems have been resolved, service may be suspended with the understanding that PACT will pursue the case again on the appropriate date.
4. The same suspension provision applies in cases where the client goes into residential treatment.

Other continuations include cases where counselors are still in the throes of intensive service. In each case, a tentative termination date is set.

Case Termination

Termination of a case is probably the most difficult and complicated of service and reporting procedures. There is a large range of criteria to apply and the procedure itself is complex.

Criteria for Termination

A family may be terminated if the goals of service have been met. In this case, the following criteria apply:

1. parent coping well and has disciplinary control of her children
2. children have been returned home and made a positive adjustment
3. children in the home are no longer at risk of placement and are cooperating with required routines

4. positive interaction and affection evident between parent and children
5. housing and home environment adequate
6. health standards are being met and any outstanding health problems are covered by some form of service
7. acceptable nutritional practices are being followed
8. family has stable source of income and budgets money satisfactorily
9. family makes appropriate use of community and social resources in order to stabilize and enhance their living situation
10. parent and children have achieved some self-esteem and sensitivity and respect for each other's needs, strengths, and limitations
11. concrete assurance has been attained that any outstanding problems will be handled by services to which the family has been referred

A family also may be terminated from service if, after three months of service, all or most of the criteria for goals of service have not been met, and it appears unlikely that they will be met in the next three or four months. In this case, one or more of the following criteria may apply:

1. family has made themselves consistently unavailable for PACT service
2. family has moved out of area
3. parent has been hospitalized or incarcerated and will not be available for service or able to benefit from service for three months or more
4. parent refuses PACT service

For those families where the goals of service have not been met, the following recommendations might be made, depending on the situation:

1. Termination of parental rights: if there is clear evidence and consistent documentation of gross neglect or abuse and enduring parental incompetence.
2. Short-term foster care: if there is evidence of parental strengths that can be built on in the future to develop parental competency, or where the parent is incapacitated for the time being.
3. Guardianship: for the same reasons as recommendation 2, and also in cases falling between recommendations 1 and 2 in which long-term foster care seems like a more appropriate solution.

The type of foster care placement, whether group home, institution, or family home, depends on the individual characteristics of the situation and children.

In the cases of families who are unavailable, have refused services, or have moved out of the area, the situation is usually out of PACT's control. However, the full reporting procedure must be completed for these cases as well as all other types of termination.

Termination Procedure

For those cases where the counselor believes that termination is appropriate, the following procedure is followed:

1. The counselors confer with supervisors about the reasons for termination.

If termination is then decided on:

2. The counselors confer with the DSS Foster Care or Protective Services worker regarding the plan for termination.

If termination is then still the plan:

3. The counselors confer with the parent and review the goals of service and progress made to date. They discuss tentative plans to terminate and ask the parent for her or his opinion on the matter. If the parent resists termination, it may be best to hold off for a while, suggesting a possible date three or four weeks in the future for termination and thus gradually preparing the parent for the time termination will occur. If there is to be a case conference with the parent involved, the counselors prepare her or him for it. They discuss each person who will be present, what will transpire, and what to expect. Sometimes a role playing of the case conference is called for.

If termination is to proceed:

4. The counselors call a case conference with each of the agencies involved and ask them to send their representatives to the conference. It is preferable to have the parent present if possible.
5. The counselors arrange for the referrals for service from other agencies to take care of outstanding problems and follow through to see that these services are supplied to the family.
6. The counselors complete a thorough termination report for the referring DSS worker with prior review by the PACT supervisor.
7. Counselors follow through on their recommendations in the DSS termination report.

The remaining steps involve counselor completion of a number of evaluation forms measuring the target child's adjustment, parent-child interaction, a final assessment of goal completion, and an evaluation report for termination.

In a final parent interview, the counselors indicate that they will be available for emergencies that may arise. If appropriate, the parent may continue to attend the parent workshops. However, for a situation where the counselors are recommending termination of parent rights, PACT does not encourage the parent to attend the workshops since this might raise false hopes. Instead, a referral for a fulfilling activity elsewhere is promoted. In some cases, surrogate sibling involvement continues after families have been terminated from intensive service. The Termination Report utilizes the anecdotal method and deals with considerable specificity in reporting the progress the family has made. An example of the report, submitted to Protective Services, follows.

Termination Report

Client Name: Laura Sweeney
Initial Visit: 9-21-77
Date of Termination: 1-15-78
Referral Source: Protective Services
Reason for Referral: Children were removed for neglect. Mother had left children alone during the day, apartment had no heat or food.

I. Parents, Children and Others Residing in Home:
Mother—Laura Sweeney 1-20-55
Son—Alfred 6-2-70
Son—Allan 3-1-72
Son—Leon 8-11-73

Daughter—Sharon 4-1-75
Mother's brother—Frank

II. Evaluation of Service Plan

PACT counselors feel that Mrs. Sweeney has responded very positively to their encouragement and involvement with the family.

In the general area of parenting skills PACT counselors have observed a marked improvement in the areas of budgeting and nutrition. The mother appears to be very highly motivated and shows a healthy concern pertaining to the physical and mental well being of her family. She provides a very warm, cheerful and stimulating environment for her family. Recently she requested and was provided with interior latex paint by PACT. Within two days she and her brother Frank had very decoratively painted trim in the living room area, some walls and a storage cabinet in the kitchen, and the entire bathroom. The home has a cheerful appearance which seems to reflect the general positive attitude within.

The children appear well cared for. They are always adequately and attractively dressed.

They also appear quite enthusiastic about school. The mother frequently displays their artistic creations, homework and schoolwork papers on the walls of the living room and kitchen.

PACT workers feel that much of this progress concerning the overall lifestyle of the family is due to the mother's highly motivated and positive attitude.

A. Budgeting:

As previously reported the mother appears to have a good sense of budgeting and "stretching" her available resources to meet her family's needs. She makes very good use of donations acquired from the PACT resources and is quite creative in recycling available materials and apparel into very useful clothing and household items.

B. Home Management Skills:

Mrs. Sweeney seems to create a positive, stimulating and orderly environment for her family. She has been observed on several occasions to respond with interest and enthusiasm to her children's demands for involvement with schoolwork or conversation, and on one occasion a school project of selling candy. On this occasion PACT workers arrived for an unscheduled visit to find the mother preparing to accompany Alfred and Allan to solicit funds from the neighbors for the candy sale drive.

C. Health Standards:

Mrs. Sweeney has been observed on several occasions keeping medical appointments for her children. PACT workers provide transportation for the mother and Leon to the Vocational Rehabilitation Center for appointments that she had made for herself and Leon. After this visit she has independently kept the appointments.

The purpose for these appointments is to facilitate communication skills for the mother and her son, who is hearing impaired and therefore does not speak. Since her involvement with Voc. Rehab., the mother often encourages Leon to communicate with others and proudly discusses and demonstrates his new skills. The mother also appears to be very encouraged concerning the developments in her ability to communicate with her child. She appears to be continuously increasing her awareness and sensitivity to Leon's difficulties, and appears to be quite pleased with her progress.

The mother frequently and openly asks questions concerning the physical care of herself and her family. On one occasion PACT workers engaged in a lengthy discussion with the mother and her brother Frank concerning

good dental hygiene and care techniques. The conversation was initiated by questions from the mother and she again was very open to increasing her knowledge to help herself and her family.

The family also appears to attend church and Sunday school regularly.

D. Parent-child Interaction:

PACT workers and the parent workshop directors at PACT who have been involved with the mother are somewhat concerned with Mrs. Sweeney's awareness of age appropriate behavior for her children and discipline techniques. For this reason the mother is enrolled in the next parent workshop session concerning discipline. She is very willing to attend. Also the PACT counselors have introduced a text to the mother and provided her with a copy (concerning appropriate parent-child interactions).

Workers feel that her level of interest and involvement in the previous workshops are good indicators that the mother will benefit greatly from these sessions.

When visiting the home and interacting with the family on other occasions, PACT counselors have felt that there is a good attachment level between the mother and children. The children are usually quite free and comfortable around the mother and brother in their home environment. They interact quite well with adults and display healthy self-concept attitudes. Leon has frequently been quite assertive in gaining his share of attention also. In most cases he accomplished this in an appropriate manner. All the children appear quite affectionate.

The mother appears to enjoy her children and shares in their enjoyment and accomplishments. At times she has displayed concern that the children were active and felt their behavior was inappropriate. On these occasions the counselors attempted to make her aware that the behavior was usually quite appropriate relative to the situation and the children's ages.

E. Mother's Physical and Mental Health:

As stated previously Mrs. Sweeney appears to be in good health and practices good physical health habits. She appears to be very enthusiastic and highly motivated to continually improve herself and thereby her family's general well being. Her self image appears to have grown quite positively. She is currently enrolled in a GED program and looks forward to the possibility of a work training program. She values independence and seems to be working toward better achieving that goal. She appears to be gaining a much better sense of responsibility. She also seems to practice good decision making procedures and appears to understand cause and effect in this process.

III. Recommendation:

PACT workers have enjoyed working with Mrs. Sweeney and her family. Counselors feel that Mrs. Sweeney, due to her strengths and motivation, will be able to continue to do well in her resumed role as a parent. She will be attending the upcoming parent workshop at PACT and, depending on the content of the following workshop, may be encouraged to attend that session also.

PACT workers feel that a minimal but consistent contact and encouragement from Protective Services to Mrs. Sweeney would be beneficial in their monitoring and follow-up of the family's progress. Counselors will stress continuation of communication counseling at Voc. Rehab. with Leon as vital. Counselors also urge monitoring children's school progress and will encourage that Sharon soon attend day care and/or preschool program.

PACT Workers: D. Miller
S. Meagher

Furthermore, upon termination PACT urges clients to call their counselors if a serious problem arises which they feel the program can help to resolve. For those clients not covered by existing service vehicles, PACT intends to conduct follow-up interviews at regular intervals: three months, six months, and a year after termination.

Auxiliary Services

Though not part of the original plan for PACT, auxiliary services were developed to meet needs which emerged in the course of the program's work. Funded in part by money available for professional consultation to project staff, they are almost entirely direct services to clients. Consultation monies were used in this way because there seemed to be at least as much need for direct comprehensive services to clients as there was for the purpose for which funds were originally intended. The bank of auxiliary services enables supervisors and counselors to put together different treatment combinations specifically suited to individual client needs. Establishment of these services within the project promotes efficient delivery, cross-checks of client progress, and flexibility in treatment plans. The individual delivering auxiliary services often has an opportunity to see the client from a different perspective, and therefore may contribute to the relevancy of the treatment plan.

In all, there are nine auxiliary services, including community resources, parent workshops, childcare during workshops, moving, donations, home repairs, surrogate brothers and sisters, surrogate parents, and mental health consultation on treatment design. Many of these services are directed by PACT counselors who receive both additional hours of employment and a chance to develop a variety of leadership and professional skills.

Community Resources

Identification of resources outside the project is an essential aspect of service delivery. The resource coordinator therefore devotes ten hours a week to researching resources within the community, compiling a community resources directory, and posting timely resources such as housing, special events, and financial aid programs for low-income families. Additional resources are constantly identified by the counselors themselves, who in turn convey such information to the resource coordinator along with a brief statement concerning the quality of response from the resource.

Among the most important aspects of the resource coordinator's job is a housing search, because parents of abused or neglected children often are required to obtain improved housing. Each week the resource coordinator reads the newspapers for rental housing ads, calls real estate contacts, and sometimes cruises neighborhoods in search of suitable housing. A rent subsidy program, discount or free tickets for special events, low or no cost summer camp programs, special learning programs in addition to myriad health, mental health, and counseling programs are some of the resources included in the coordinator's search. The coordinator also identifies sources of specialized information in the form of speakers, literature, or films.

Parent Workshops

Each client is invited and strongly advised to attend PACT's parent workshops. PACT now has three gradated workshops, each of which meets for two hours over an eight-week period. Child care is available during the workshops. The workshops coordinator is a master's candidate in human development with emphasis in parenting and was previously employed by PACT as a counselor. She has been assisted by a doctoral candidate in clinical psychology who also serves as PACT's mental health consultant. The workshop for

a particular day is also an all-day affair for one or another of the PACT staff because of its organizational requirements and the necessity to provide transportation to and from the workshop for parents and children. PACT views this transportation as the key to workshop attendance. Many clients need the extra push that transportation gives in order to assure their attendance.

The parent workshops provide clients with an opportunity to learn parenting skills and relax over coffee while socializing with clients in similar circumstances. The sessions are intended to aid clients in understanding their own and their children's behavior with the hope that they will thus become better parents. In fact, the Wayne County Juvenile Court considers attendance at these workshops to be points in favor of the client who has been ordered to learn parenting skills as a requirement for keeping his or her children at home or having them returned.

The workshops are not meant to be therapy sessions or solve the needs of any one person. Through sharing their concerns and themselves, clients learn to give and take advice from their peers in a way that might not be as effective on a one-to-one basis. Within certain broad areas of focus, all kinds of topics are discussed, some of the most common being relationships, age-appropriate behavior discipline, sex education, independence, teaching children, dealing with anger and using community resources. The particular topics arise out of the needs of the clients and are developed on the spot. Workshop leaders try to generalize any problem that comes up so that it could apply to anyone there and everyone may benefit from the discussion.

The first workshop focuses on fostering a sense of commonality of experience, personalization of issues and problems, and familiarity with the group process. The second session focuses on particular issues and emphasizes parenting skills and parent effectiveness. Upon completion of these, an individual parent may be given the choice of entering the third workshop. Those asked to participate have been previously evaluated in terms of requisite skills and potential to benefit from the experience offered. This last workshop at times has concentrated on the personal needs clients have which are separate from the needs of their children. During the most recent session the third workshop concentrated on assertiveness training. The meeting log reproduced below illustrates the approach taken and the issues dealt with during the workshop.

> Goal: Continue to foster self-awareness and taking responsibility for one's own life through assertive training techniques.
>
> Narrative: Because Barbara had been away, we decided to open by asking everyone to catch her up on where they were in their lives and in the group over the past few weeks. This served to reorient the group leaders and also to invite people to focus on and assess these issues for themselves personally. This was very effective because it allowed for checking in, bridging between sessions, time for new personal issues, and flowed quite naturally toward the presentation of today's material.
>
> Next we completed the assertiveness training material on discipline and problem solving. Again, as they were last week, the group was very receptive to these ideas and appeared to personalize them and relate them to home. Discussion was simultaneous with instruction. This allowed for spontaneous role play, suggestions, and exploration of real ongoing discipline issues and problems and relating these concretely to the ideas presented. Some of the concepts covered were:
>
> 1. A child who takes responsibility for telling the mother what to do and how to ease this child out of the advocate role while inviting her to assertively express what she thinks, feels, and wants.

2. Appropriate reasonable punishment that is relevant to the behavior, provides learning, and does not put the child down or make the issue disproportionately heavy.
3. Allowing the child choice by explaining reasonable negative consequences ahead of time. Choices versus threat.
4. The importance of consistency in following through should the negative consequence be chosen by the child. No need for yelling and put-downs.
5. Address the overt behavior and not the child's personality and inner dispositions.
6. Praise as a learning tool. Be on the lookout for the good as a means to discipline, not just the bad or objectionable.
7. Children's fighting as an attention-getting device and how not to reinforce this.
8. Encouraging children to resolve their own conflicts reasonably and teaching them how to do so.
9. People learn best when they experience the natural consequences of their own behavior (within reasonable limits).
10. Teaching children cause-and-effect thinking.
11. It is often necessary to believe a child who says he didn't do something because it may be the truth. Find out what really happened.
12. The assertive problem-solving steps.

The participants were encouraged to think over their goals and this group carefully for the upcoming personal evaluation of this experience. As a closing, everyone was asked to share how they were doing on actually discarding the self-defeating behavior that was done symbolically two weeks ago. They were also asked to examine this carefully toward the idea of developing some next steps, for the workshop is soon ending.

Attendance and Participants notes:

Sandra: Valuable as always. Vented a lot of anger toward her mother, who is presently staying with her. It was good to see Sandra take care of her own needs in the group today. She usually spends most of the sessions helping others and expanding concepts with useful examples and suggestions. She continues to handle Priscilla's evangelizing better and better.

Joan: Appeared to follow the session fairly well. But she provided many life experience examples that were just off the mark and required much group leader effort to focus them and relate them to the ideas being discussed.

Virginia: Has just recently rented a large house and things seem to be going well for her at this time. Shared relevant issues in her life and was very focused on her personal growth issues. Great participant.

Priscilla: Plans to try to buy a four-family flat on a land contract. She shared at a rather superficial level in today's session. Remains a bit above it all and more blessed than everyone else, although Sandra countered this effectively and with great tact.

Mary: Very quiet today. Difficult to tell to what extent she was able to follow the discussion. Her problem-solving strategy appears to be to accept advice from others. I do not believe that she is in touch at all with the process.

Jenny: Seems to be gaining considerable control in her life and taking charge. She also appears to really benefit from the concepts presented. Great participant.

Evaluation of session: The assertiveness training material is highly effective both pedantically and as a stimulus for the exploration of self and how one relates to others. As such, I believe it to be a valuable tool for this Personal Growth Workshop. This session went very well, but more time can be spent on the assertive problem-solving steps themselves. The group appears ready to move into the assessment and termination phase.

Mistakes to learn from and points to remember: 1. Check in on goals more often as a means to focus attention toward ongoing self-assessment—progress and next steps. 2. Move into the group termination phase.

M. Strang and B. Sugerman

Child Care

PACT sometimes provides short-term child care for children in their own homes during crises, but the project's regular childcare services are provided during the parent workshops. This child care is available for all age groups, and activities are designed to meet the specific needs of the children in each group. The childcare coordinator is one of the PACT counselors who holds a bachelor's degree in child development and is currently working on a master's degree in the human development program. She is assisted by other PACT counselors and part-time childcare aides who have taken child development and parenting courses in the Department of Family and Consumer Resources curriculum.

PACT's child care has been directed mainly toward purposefully meeting the developmental needs of the children. Thus for children from infancy to age six, fine and gross motor skills, cognitive skills, and personal social activities are emphasized. More individualized activities are often planned for school-age children where the need might exist for socialization experiences, mind broadening experiences, tutoring in a specific school subject, or development of coordination through specific physical exercise. The following is a summary of childcare sessions for the latter group over a period of four weeks.

The first week we went to Old Main, an old campus building filled with unusual places and fun to explore. We saw the inner courtyard, a first-aid class in progress, and the entire wall of dance mirrors. The sheer novelty of moving from place to place kept the kids well behaved.

I started the workshop with body placement exercises and treated them to various games to help them notice things, such as "Mirror Game" and "Follow the Leader."

The second week, only Tim and Chris went with me to explore the Art Building pond. The third week, the beginning exercises were already a regular thing. They are familiar with them and know why they are done and are ready to move on to more complicated exercises.

For the exploration trip of the third week, we explored the Student Center Building and went up to the 7th floor to look out a high window. They didn't believe churches were in the building. So we went to look at the Catholic chapel. Services were just concluding and the people there showed them around. Then we went to the pond to splash around as we originally planned.

For the fourth week, I planned a total physical time of play exercises, but it did not work out well due to lack of kids. But I took some youngsters who arrived early to see the Natural History Museum in Old Main where they saw a stuffed tiger, a lion skin, and many other fascinating "critters." Their response was enthusiastic and it was difficult to get them to leave when it came time.

As usual, their nose-poking curiosity got them into a place that wasn't on the

agenda. We discovered the guy who was in charge of stuffing the birds. He had a whole tray of them out and explained a lot about how he did it. The kids were well behaved and asked intelligent questions.

For the fifth week, I plan to go into more complicated exercises in a different place. The front porch has become much too distracting with all the construction. I plan to teach more postural exercises and more flexibility exercises. I will have to think of a more vigorous game to get them warmed up for their day's exploration. Perhaps tag or "monster tag."

Today we are going to the Detroit Historical Museum to see old cars and train sets, but particularly to see "The Streets of Old Detroit," which is a total reconstruction of the way Detroit streets looked at different times in history. What will happen is difficult to say, but it will be a sure test to their powers of observation because this particular group of kids is so literate that I will have them use their love of reading and writing.

First I will ask them to make a list of ten things they never saw before and to save it. Then in a surprise move, I will ask them to draw one or two of those things when we get back. We will see what happens.

J. Stanley

More recently, PACT has been experimenting in one workshop with modeling caregiver and child interaction. Activities are selected for their maximum modeling potential. Workshop leaders first inform parents as to the activity they will later observe in the childcare center; in some cases, parents simulate the activity, such as making hand puppets or collages, and while doing so are instructed in the process the child goes through while completing the activity so that they are sensitive to what the child is experiencing. This process is then related to the child's developmental needs. The parents are asked to comment on what they observed and how they interpreted it. Through the combination of experience, observation, and discussion, such a modeling approach has the advantage of focusing on the kinds of behavior to expect of a child of a particular age and how a parent might work complementarily with those behaviors, thereby fostering the child's growth and development.

If the current experiment shows promise, PACT expects to integrate this workshop with the parenting practicum offered in the Department of Family and Consumer Resources. Practicum students will thereby gain experience in working with low-income parents and children in the context of addressing specific developmental processes. PACT will gain additional childcare help and purposeful expansion of client experience.

Moving Service and Donations

Frequently an important part of a client's treatment plan consists in physically moving the family to suitable housing. Not only does this service meet an observable need in such cases, but often it is one which the court has mandated before children may be returned, and in some cases it is essential to forestall placement. PACT views its moving service as one of the possible preliminaries to improving the client's sense of hope and well-being. The client's disposition may then be receptive to other, less material aspects of service.

PACT's moving service includes not only physically relocating the client but supplying him or her with any necessary furnishings and appliances. Most of these goods are acquired as donations from affluent households. Donations also include children's and adult's clothing and books and toys. The project has set aside one regular day a week for this service. Counselors are required to submit their requests for client moves or donations

one week in advance. Clients will be scheduled for moving on this day, or donations may be picked up and stored or delivered directly to clients' homes via a step van rented through the university.

Home Repair

One regularly scheduled day each week is reserved for helping clients take care of minor repairs in their homes. In a sense this activity is a modeling technique whereby the counselor, in scheduling the service, conveys a sense of pride in making the home environment as conducive to wholesome living as possible. In actually performing the service, the home repair crew demonstrates how these repairs can be accomplished, and whenever possible enlists the aid of family members. This service also is viewed as one way of restoring a client's sense of hope and self-esteem. Developing pride in one's home environment is perceived as giving the client a chance to gain control over his or her life and therefore feel that a stable foundation exists for planning and moving ahead toward other improvements.

> To alleviate the most immediate problems with the Jones' environment, PACT's home repair team made several needed repairs: of locks and doorknobs in the front and back doors and of steps to the basement. We stopped there because the best solution was still moving them out. There are major repairs to be done (leak in the roof, big hole in the kitchen ceiling, old pipes, etc.) that PACT couldn't get involved with. But Richard, the 16-year-old son who had just started working during the summer, decided on his own to improve their house. He bought new linoleums for the floors, painted the walls, and panelled the living room. Richard was inexperienced and has few tools to work with. He cut the panelling with a knife instead of a saw and nailed it to the walls.
>
> I was very pleased and surprised to see his involvement and the ingenuity of his efforts. I reported to the office and made a request for PACT's home repair team to go back and help him finish the job with knowledgable advice. We told Richard in a tactful way that we could help him complete the work already started. The repair team bought more supplies and taught Richard and his brothers how to finish the panelling, etc. They will also fix the big hole in the kitchen ceiling. PACT is going to pay for a professional extermination job because roaches are out of control. Some things will be impossible for PACT to repair, but those things accomplished have been a big improvement to the environment and attitude of this family.
>
> The fact that the 16-year-old boy used the earnings from his first job as he did made us all proud of him. It more than justifies the encouragement we gave him, though the need of the family to move to a better place hasn't disappeared.
>
> This is a tailor-made example of how the common effort of client and agency can help improve the overall family living conditions.
>
> B. Lande

Surrogate Siblings

In a number of cases, PACT has found that there are one or two children critically in need of a significant, guiding relationship just for themselves. Not only does this need exist, but its fulfillment is often central to dislodging the family from a rut of chronic discouragement. In the midst of the hopelessness brought about by one or two children's repeated and apparently insurmountable problem behavior, other problems become heavier and the family feels helpless to deal constructively with its existence.

In other cases, PACT has encountered clients who, despite the counselors' persistent
56 efforts, will not and perhaps cannot become engaged in a fruitful relationship. Yet these

clients will readily agree to the project working with their children, who often show an interest in developing ties with a surrogate brother or sister. Sometimes in such cases it is more reasonable and profitable to discontinue intensive service to the parent while continuing the surrogate relationship.

> There are times when it's clear after only a short period of involvement that PACT's intervention is not working with a family, and the case of Naomi illustrates this well. Naomi has emotional problems and is angry most of the time. This anger is usually directed at her children, especially her oldest daughter, Diane, age 10. Although she is not violent, this client yells constantly and rarely shows affection to her children. Her mother's anger and resentment, plus the fact that she was raped last year, have caused Diane to develop emotional problems of her own, for which she is receiving counseling.
>
> At the time of our involvement, the family's living situation was stable. The apartment they lived in was adequate and fairly well furnished, and Naomi was able to manage the home and her small ADC check quite well.
>
> Our initial goals were to better the relationship between the mother and her children by modeling more effective discipline techniques, and hopefully getting Naomi into therapy. Efforts towards these goals failed completely. Naomi was resentful of our presence and refused to acknowledge the possibility that she might have a problem. It soon became apparent that PACT's intervention would not be useful due to the uncooperativeness of the client.
>
> After discussing my reluctance to "abandon" the children by terminating the family (there were no grounds for court removal), my supervisor suggested finding a surrogate sister for Diane and Alice, the two girls. John, their brother, already had a surrogate brother working with him.
>
> It was the ideal solution—the PACT counseling team would be freed from an ineffective situation and would be able to work with another, more cooperative family, while the children would still receive support from PACT's surrogate program. Both Naomi and the children accepted the idea readily, and we were able to terminate the family with the knowledge that someone would be there to monitor the situation and help the children learn to deal with their mother's anger.
>
> D. Kade

Surrogate involvement might also be continued if the goals of intensive service have been achieved but surrogate goals have not. Such continued but less intensive involvement also provides the bonus of supplying follow-up reports on the client's progress.

The activities shared by surrogate and child usually occur once a week and are designed to be purposeful and specific to the child's needs. For example, one seven-year-old boy with a learning disability was about to attend school for the first time when the surrogate relationship began. Frequent family moves and lack of evaluation by a school had prevented the boy from yet being placed in a suitable learning situation. The child was very uneasy about the imminent and new experience, particularly since he was starting much later than others his age. The surrogate brother assigned to the boy concentrated on the school problem, demonstrating through books, discussions, and excursions that learning can be fun. He then rewarded the boy for regular attendance at school (the child found a multitude of excuses for not going at first), and helped him complete his homework and understand his lessons. As the boy made progress in school his confidence grew. He is now functioning at grade level and able to get along with less frequent visits from the surrogate. In this particular case, some of the outings included visits to the surrogate's own

large family in Detroit, where the boy was shown much understanding, affection, and respect. Though not a scheduled part of program service, possibly this experience helped the boy feel more complete and valuable. These visits will continue from time to time because the surrogate's family is interested in maintaining contact with the child.

Surrogate Parents

Successful treatment in abuse and neglect cases depends to a large extent on reeducating and motivating primary caretakers actively to pursue positive and productive living patterns. The groundwork for this change in behavior has been successfully established by PACT in a number of cases. However, crises often occur during treatment in which the availability of a substitute caretaker or supportive and level-headed friend or observer could perhaps make the difference between the family remaining intact or breaking up. In addition, the solidification of treatment sometimes requires that a competent person remain involved with the case near the time of or following termination of intensive service.

To fill these roles, PACT has utilized the competencies and skills of a few former clients who have demonstrated their acquired abilities to manage their own family's lives and are ready to communicate their learning to others.

PACT instituted this component in order to promote employment for some of the mothers enrolled in the program and to provide peer modeling for families. These parents were assigned to individual families, much like the surrogate brothers and sisters, in order to help clients in specific problem areas.

The families to which the parents have been assigned include one in which the mother was hospitalized, two in which the parents were elderly women, and one in which the mother was an emotionally disturbed adolescent whose children had been placed in foster care. Surrogate parents step in and perform such duties as helping in meal preparation, organizing the children around household chores, assisting in organizing a new home, encouraging the parents' social skills and positive interaction with their children, and befriending them. When surrogates are not busy with client assignments, they are given tasks to complete in the PACT office. The work assignments at the PACT office include sorting the many donations that the project receives, maintaining the organization of these donations, and assisting other parents in picking up needed items while they are at the office.

The surrogate parents are supervised directly by a counselor who has ten hours a week to devote to them under PACT's additional services plan. The counselor holds regularly scheduled meetings with them to check their progress, offer needed guidance and encouragement, and assign new work situations. In addition, the counselor confers with the supervisory staff in assessing the surrogate parent's abilities in order to place them in an appropriate work assignment. These experiences have been rewarding for the surrogate parents involved as well as extremely helpful to the PACT staff. In only two family situations were the services terminated because recipients were not receptive to peer models in their home.

PACT is only one of many projects which have found that surrogate parents can play an effective role in preventing child abuse and neglect. As peer model and friend, the surrogate parent provides the client with a living example of someone who has managed to gain control of home and environment. The surrogate parent also fulfills the need often cited in abusive families for the nurturing and supportive influence of a personally and socially intact mothering figure. A surrogate parent program not only fills an important gap in services, but offers training and job experience to low-income parents. The experience

of earning a paycheck increases self-esteem to the point that these parents come to view themselves as possessing marketable skills and provides the bridge to their seeking permanent employment beyond the project.

The current surrogate parent program at PACT suffers from a number of deficits, however, all related to a shortage of funds. More money is needed to expand the number of surrogates working in the program, to establish full-time direction of the program, to provide more structured on-going training and to integrate PACT's core services and the surrogate parent component on a regular basis. PACT proposes to expand this program by offering part-time employment not only to project clients of proven competency but to other able low-income parents in Wayne County who would be recruited by the project staff. With adequate funds, the present program could be integrated more satisfactorily into the core service program and assured of uniform supervision.

Mental Health Consultant

PACT does not offer psychotherapy as one of its services, yet a number of clients come to the project with psychological disorders ranging from those caused by circumstantial problems in living to periodic breaks with reality. The latter have proved extremely resistant to progress and have therefore constituted the largest single segment of program failures. These cases are not appropriate referrals for program service. A more stringent application of eligibility criteria in the future will prevent such cases from being admitted to the project caseload.

In those cases with temporary disturbances due to problems in living, PACT regularly employs the services of a mental health consultant who is a doctoral candidate in clinical psychology at Wayne State University. At project weekly group meetings, three or four cases with such problems are selected for discussion. With the guidance of the mental health consultant and project director, staff input concerning the problems is encouraged so that the treatment strategies which emerge become part of each counselor's training experience. The mental health consultant is also available to counselors two mornings a week for one-to-one discussions of client problems.

PACT takes the view that the counselors possess the sophistication and skill to carry out a quasi-mental health treatment plan once the course has been laid out under the guidance of the consultant. The procedure makes such treatment available to a greater number of clients at a lower cost than the provision of direct psychotherapy. However, the program does not attempt to treat severe mental health problems. These clients are referred elsewhere for psychotherapy.

The mental health consultant's insight and knowledge regarding client problems have been substantially enhanced by her leadership in the parent workshops. She is able to bring a different perspective to bear on the counselor's perspective, and clients may also respond differently. Sometimes it seems that the client views intensive service as having very practical goals, whereas the workshops are seen as dealing with attitudes, personal issues, values, and feelings; the client perhaps participates in each accordingly. The mental health consultant contributes toward expanding counselor awareness of the client's psychological position regarding his or her situation. The client becomes more of a known quantity and therefore more accessible to motivation by the counselor. Thus the assimilation of findings from workshop and intensive service, via the mental health consultant, forms a strong integrating element in treatment plans. To increase understanding of client situations and integration of planning, the mental health consultant visits clients' homes with the counselors where particularly difficult problems indicate the need.

The mental health consultant also assists in the on-going training of counselors, surrogate siblings, and surrogate parents. She has conducted group sessions for each of these groups in communication and listening skills, value clarification, crises procedures, modeling and demonstrating techniques, and assertivness techniques.

Follow-up Modes

PACT has established several modes for follow-up in order to determine if there is need to reintroduce PACT service, to refer for other services, and to conduct evaluations to ascertain rates of recidivism. Some of these follow-up modes, such as the parent workshops, surrogate brothers and sisters, and surrogate parents, are built into existing service vehicles. The client is eligible to continue attending parent workshops even after intensive service has been terminated. The surrogate brother or sister assigned to a child often continues an involvement long beyond the date of termination because the time limits for such a personal relationship elude predetermination and could be detrimental to the development of the child's trust in the surrogate. Reports from these service workers are routinely submitted to supervisors, as is the current status of those clients who have become part of PACT's surrogate parents component.

Summary

In some parts of the world, the ties to the ancestral home follow an individual wherever he/she goes. In any part of the country in question, the individual can find a friend or relative, whom he/she has perhaps never seen or known, who feels these ties also and stands ready to offer sustenance or help. There is a lot of security in knowing this kind of support exists, and it makes the world seem a place of relative safety. Such security is basic to feelings of motivation and confidence, and the ability to make a positive difference in the lives of others.

On a much smaller scale, every part of PACT's service is related in a sense to recreating this kind of extended family feeling. Examples include the client identification with counselors via a relationship tied to modeling and demonstration techniques; a "safe" social forum for expressing ideas and fears in parenting workshops; special recognition of children's needs and desires through advocacy, tutoring, outings and gifts on birthdays; provision of material needs through home repairs and donations. Most closely related of all is the client's awareness of not just one worker, but a team of caring people working in his/her behalf. The client comes to know almost everyone on staff through one activity or another, and enters into a bond of sorts with many. Furthermore, the project itself has and communicates an internal family feeling which serves as a model to families.

Whether articulated or not, techniques such as modeling and demonstration, reeducation and the counseling approach, play subtle or not-so-subtle parts in most intra-family relationships. In PACT these techniques are refined and enhanced because of the positive relationship which exists among parties.

When this sense of family prevails, termination is more like a promotion than a discontinuation. The relationship between project workers and clients continues, although intensive service ends. Some services even continue, such as the parent workshops and surrogate siblings, and in fact some clients have become PACT employees for a while before going on to other things. Such a continuation helps to consolidate service gains and
60 embed a sense of the world being a safer place.

PART II

Descriptive Statistics, Evaluation, and Outcomes

PART II
Descriptive Statistics, Evaluation, and Outcomes

Introduction

In the first section of Part II of the PACT Manual, Relich provides the results of service as expressed by the status of children after a minimum of two months of service, discusses the nature of problems which brought them to PACT service, and includes a description of the population served by the project. In some instances, data is available on only a segment of the population served by the project. Relich also provides descriptive statistics on services provided by PACT to its clientele.

In the second section of Part II, Giblin and Biasatti describe the procedures and results of a four-month research project conducted on a subset of the client population, examining any changes in the personal and social adjustments of the parents and children enrolled in PACT that occurred during four months of service.

PART II A
Descriptive Statistics: Results, Population, and Services

Rosemarie Relich

From June 15, 1977, to September 30, 1978, PACT served 108 families living in Wayne County, Michigan. Approximately one-half of the families were referred from the Foster Care Division and one-half from the Protective Services Division of Wayne County Department of Social Services. At least one quarter of the total number of families originally came to PACT's attention through private social agencies, area hospitals, public health nurses, schools and/or churches, and self referral.

Results of Service

Within the 108 families served by PACT, there was a total of 422 children or an average of four children per family. Of these children:

116 (27%) were in foster care at the beginning of service,
247 (59%) were at risk of placement, and
59 (14%) were at home and not at risk of placement.

The time period of two months was identified as the earliest date at which any degree of progress could be observed in PACT families. Therefore, of the 99 families (with a total of 324 focus children) who had experienced at least two months of service between June 15, 1977, and September 30, 1978:

214 children were initially at home and indicated at risk, and
110 children were in foster care.

As of September 30, 1978:

197 (92%) of the children initially at home and indicated at risk remained at home,
17 (8%) of the children initially at home and indicated at risk were placed into foster care,
51 (46%) of the children in foster care were returned to their natural parent(s), and
59 (54%) of the children remained in foster care, although for many, return was imminent.

Therefore, 248 children (77%) were either returned to or remained in their natural homes.

Of the children who either remained in foster care, were placed or remained at home, the project recommended permanent placement outside the natural home for 25:

19 were among those 59 who remained in foster care,
4 were among those 17 who were placed, and
2 were among the 197 who remained at home.

History of Placement

At the beginning of PACT service, 116 children were in foster care but, in addition, approximately 68 (30%) of the children at risk had experienced one or more foster care placements *before* intervention occurred.

Data was secured on the placement histories in 80 families. Of the 337 children in these families, 122 (36%) had experienced foster care placement. This does not include the 116 children currently placed. Placement is defined as one continuous period when the child(ren) is/are removed from parental custody. One continuous placement, therefore, might include one or more shifts in the child(ren)'s foster care residence. Of the 122 children who had been placed,

103 (84%) children had experienced one foster care placement,
14 (12%) children had experienced two foster care placements, and
5 (4%) children had experienced three foster care placements.

Thus, the vast majority (84%) of those who had experienced placement had been placed only once. The average length of placement for the 122 children, based on the *total* amount of time spent in foster care, was approximately 1½ years, with the range being from two days to six years. Although the majority (85 or 70%) were in placement less than two years, a substantial number (37 or 30%) were in placement at least two years or more.

An examination of the court records of the 116 children in placement at the beginning of PACT service reveals a variety of reasons for such placements. They can, however, be divided into parent and children categories. The following lists such categories and the corresponding percentages. For any one child, there may have been multiple reasons for placement. Thus, these are overlapping categories.

Parent Categories Leading to Placement

Reasons	Percentages
Physical, medical, educational neglect	38 %
Physical, psychological, sexual abuse	20 %
Mental illness	10 %
Abandonment	4 %
Hospitalization	4 %
Conjugal discord	4 %
Mental retardation	4 %
Substance abuse	4 %
Inadequate housing	2 %
Incarceration	.6%

Children's Categories Leading to Placement

Reasons	Percentages
Antisocial behavior in child	7 %
Child emotionally disturbed	3 %
Child physically incapacitated	2 %
Child mentally retarded	.6%

Frequency of Client Problems

Initially, specific problem areas were noted and documented on all enrolled families during the first three weeks of service and during subsequent months of service to discern any increase or decrease in such problem areas. (See following section for a full description of problem areas, statistical analysis, and results thereof.)

A sample of 51 families was assessed as to the frequency of problem areas noted during service. The following list describes the number of families who exhibited problems *initially* in each major category and their corresponding percentages based on the sample. These figures represent overlapping categories.

Frequency of Problems Initially Noted

Problem Areas	Absolute Number*	Percentages*
Environment	43	84 %
Lack of parental independence	39	76 %
Finances	34	67 %
Parenting skills	34	67 %
Developmental lags in children	29	57 %
Health care problems	28	57 %
Physical ailments in parents	25	49 %
Social services	23	45 %
Nutrition	20	39 %
School-related	18	35 %
Community resources	18	35 %
Mental health ailments	17	33 %
Foster care	13	25 %
Physical ailments in children	10	20 %
Behavior of target child	8	16 %
Conjugal discord	6	12 %
Appearance of target child	4	8 %
Delinquency	0	

*It must be noted that the number of families reported in each problem category differed from month to month, indicative of the knowledge gained by each counselor team of their respective families' needs and concerns as well as the growing rapport between client and counselor which facilitated more exchange of information concerning specific family situation.

Disposition of Total Caseload

Total Number of Referrals

From June 15, 1977, to September 30, 1978, a total of 226 families was referred to PACT:

108 (48%) families were accepted,
82 (36%) families were rejected (see discussion of eligibility criteria),
36 (16%) families were pending as of September 30, 1978.

Active Cases

As of September 30, 1978, there were 48 active cases being serviced by PACT staff, with a total of 214 children, of whom

43 (20%) were in placement at the beginning of service,
147 (69%) were at risk of placement,
24 (11%) were at home and not at risk.

Thus, 190 children (89%) were the focus of project service.

As of September 30, 1978, after two months of service,

19 of the children originally in placement had been returned home, and
45 were no longer at risk of placement.

Of the remaining 126 children,

102 are still at risk, and
24 are in placement.

Of these 48 active cases,

22 (46%) families had been enrolled in PACT for 6½ months or more,
10 (21%) families had been enrolled between 3½ months and 6 months,

10 (21%) families had been enrolled between 1½ and 3 months,
6 (12%) families had been enrolled for 1 month or less.

Terminated Cases

As of September 30, 1978, a total of 60 families had been terminated from PACT's services. Table II:1 provides a breakdown of the length of time in service and the particular reasons for termination.

As indicated in Table II:1, in two categories: (IA) Families successfully stabilized, and (IB and IIA) Evidence of progress toward stabilization, 37 families of the total 60 achieved some degree of progress. In another ten families, permanent placement was planned. Thus, for 47 (78%) families, the lives of the children were measurably improved.

IA	Families successfully stabilized	16
IB	Families with evidence of progress toward stabilization and children at home/returned	17
IIA	Families with evidence of progress toward stabilization and some children placed/not returned	4
III	Families with permanent placement plans for the children	10
		47

In the remaining category, Families not stabilized (IC and IIB), 13 families (22%) made very little progress, either due to their lack of motivation, unavailability, and/or refusal of services, mental and/or physical ailments and addictions or bureaucratic error.

IC	Families not stabilized and children at home/returned	3
IIB	Families not stabilized and some children placed/not returned	10
		13

The average length of service among the total number of terminations was six months with the median being five months and the mode, five and six months. Whereas the median for length of service for families achieving stabilization was six months and the mode, six months, the median for families not stabilized was approximately three months and the mode, two months. Families in which a permanent placement recommendation was the final outcome tended to remain in service an average of six months.

Description of Population Served

Demographics: Family

Race and Age

Of the total number of families,
75% were Black,
22% were Caucasian, and
3% were Hispanic.

Furthermore, of the parents,

17% were between 18 and 20 years,
26% were between 21 and 25 years,
28% were between 26 and 35 years,
18% were between 36 and 45 years,
7% were between 46 and 55 years, and
4% were over 55 years.

Sex and Marital Status

Of the total number of parents,
45% had never been married,
25% were separated (legally and/or physically),
15% were married,
10% had been divorced, and
5% were widowed.

There were only two single male heads of households, thus, almost 85% of the families being serviced were headed by single parent females.

Education

Of the 45 families on which PACT had educational histories,
13% had completed some level of elementary education,
62% had completed some level of secondary education,
18% had received high school diplomas,
2% had attended college classes, and
5% had attended special education institutions.

In sum, the majority of the parents had completed some level of high school but did not have a high school diploma.

Residence

With regard to places of residence and the total number of families,
52% lived in a house,
32% resided in an apartment or flat, and
9% lived in public housing.

The remaining 7% resided in rooming houses, halfway homes or hotels. The majority were tenants of the property in which they resided.

Finances

In relation to financial status and the total caseload,
90% of the major caretakers were unemployed,
7% were employed full time, and
3% were employed part time.

In terms of source of support,
65% received some form of welfare benefits,
14% supported themselves from salaries earned by either the major caretaker and/or cohabitant,
9% received sporadic donations from relatives and friends,
5% received social security,

Table II:1 Termination of PACT Services

	Length of Service						
	Less than 1 month	1–3 m.	3–4 m.	4–6 m.	6–13 m.	Total	Percentages
I. Families in which children remained at home/returned from foster care placement						36	60%
A. Family successfully stabilized							
1. Remained PACT case throughout service			1	2	11	14	23%
2. Referred for other relevant service				1	1	2	3%
B. Evidence of progress toward stabilization							
1. Parent's lack of motivation				1		1	2%
2. Interruption of services:							
a. Unavailable/refusal		2		2	2	6	10%
b. Parent's alcoholism							
c. Parent's psychological problems				2	1	3	5%
d. Family moved	1			3		4	6%
e. Case closed by Protective Services/Foster Care					1	1	2%
f. Case referred for other relevant services			1		1	2	3%
C. Family not stabilized							
1. Children's removal imminent					1	1	2%
2. Interruption of services:							
a. Unavailable/refusal							
b. Parent's alcoholism							
c. Parent's psychological problems		1				1	2%
d. Family moved							
e. Case closed by Protective Services/Foster Care					1	1	2%
f. Case referred for other relevant services							

II. Families in which some or all children were placed/remained in foster care placement						14	23%
A. Evidence of progress toward stabilization							
1. Placement prevented/shortened for some children; 1 or more remain in foster care		1	1		1	3	5%
2. One or more children temporarily placed					1	1	2%
B. Family not stabilized							
1. Parent lacks motivation							
2. Interruption of services:							
a. Unavailability/refusal	1	1			1	3	5%
b. Parent's alcoholism					2	2	3%
c. Parent's psychological problems	1	1	1	1		4	6%
d. Family moved		1				1	2%
e. Case closed by Protective Services/Foster Care							
f. Case referred for other relevant services							
III. Families in which one or more children were recommended for permanent placement		1		4	5	10	17%
Total families per length of service	3	8	4	16	29		

3% received unemployment insurance or some type of pension (this included guardianship funds), and

4% had no visible means of support.

Therefore, the overwhelming majority of the families' major caretakers were unemployed and two-thirds of them were collecting some form of welfare benefits. Conversely, a small minority were employed either full or part-time, and used these salaries to support their families.

Social History

Social background histories of the parents included the recording of the presence or past history of psychological disturbances (this included diagnosed mental retardation as well as diagnosed psychosis), substance abuse (drugs and/or alcohol), involvement in crime and/or incarceration. The following list reports the social history data on 91 mothers and 47 fathers.

Problem	Parent	Number
Psychological disturbances	Mother	36
	Father	7
Alcohol abuse	Mother	13
	Father	12
Drug abuse	Mother	5
	Father	5
Crime involvement	Mother	4
	Father	6
Incarceration	Mother	3
	Father	7
No incidences of above	Mother	30
	Father	10

Medical History

With regard to the 23 PACT parents who reported extraordinary health problems, the following breakdown reports only their most serious health problems:

Medical Ailments	Number
Nervous breakdowns and/or general anxiety	6
Suicide attempts	4
Serious to advanced arthritis	3
Cirrhosis of the liver	3
Active tuberculosis	2
Epilepsy	2
Spinal meningitis	1
Colostomy	1
Partial paralysis of lower extremities	1

Demographics: Children

Of the 422 children included in the PACT population, the age breakdown is as follows:

151 (36%) were 0–5 years,

70 152 (36%) were 6–12 years,

90 (22%) were 13–18 years, and
29 (6%) were 19+ years.

Developmental Status; Health Concerns

1. *Infants*

Eighteen infants, ranging in age from 2½ months to 30 months (the average age was 12 months), were selected for assessment to ascertain their level of psychomotor and cognitive functioning. These assessments were conducted by a trained developmental examiner, using the Bayley Scales of Infant Development as a testing instrument.

The average score for the cognitive development in the 18 infants was 83 (the standardized mean score for both cognitive and psychomotor parts of the Bayley Scales is 100), with a standard deviation of 20. In psychomotor development, the average score was 85, with a standard deviation of 22.

The following list includes the range of health problems of the infants tested as observed by the developmental examiner as well as through a review of existing health records.

Health Concerns	Number*
Respiratory infections during developmental examinations	6
Premature birth	5
Nutritional deficiencies (including failure to thrive)	5
Specific motoric deficits (not walking, lack of exploratory movement, etc.)	3
Verbal delays	3
Skin rashes/blotchiness	2
Possible soft neurological damage	1
Diagnosed epilepsy/cerebral palsy	1
Severely bowed legs	1
Lack of social responsiveness	1
Visual tracking problems	1
Skull fracture	1
Heart problems	1

*(Note: These statistics represent overlapping cases in several categories).

In spite of the above, ten (56%) of the infants were considered to be developmentally intact and had good prognoses. One infant, in particular, was assessed as being developmentally precocious in problem solving tasks and indeed possessed exceptionally fine motor skills for her age.

2. *Preschool/School Age Children*

A total of 55 children, from 2½ years to 12½ years (average age, 8 years), were developmentally assessed on their language, cognitive, motoric, visual, and auditory skills by a trained examiner. A combination of measurement scales was used to complete the assessment, including the Wechsler Preschool and Primary Scale of Intelligence (WPPSI), the Wechsler Intelligence Scale for Children-Revised (WISC-R), the Stanford-Binet Intelligence Scale, The Beery Developmental Test of Visual Motor Integration, Wepman Auditory Discrimination Test, and The Durrell Reading Assessment. Due to the use of a potpurri of assessments, it was impossible to obtain one indexical score for each child tested. How-

ever, Table II:2 describes the various component parts of the assessments and the percentage of children who performed at age level or above in that particular area or who exhibited deficits in that area.

Table II:2
Developmental Skills

	Number Who Completed Test Item	Component Parts	
		Age Level or Above	Below Age Level
Gross motor	50	46 or 92%	4 or 8%
Perceptual motor tasks	28	18 or 64%	10 or 36%
Picture completion tasks	23	10 or 43%	13 or 57%
Visual/fine motor integration	39	16 or 41%	23 or 59%
Vocabulary	34	8 or 24%	26 or 76%
Reading	20	2 or 10%	18 or 90%
Auditory discrimination	15	1 or 7%	14 or 93%

The table indicates that reading and vocabulary tasks were, by far, the most difficult for the children to succeed in, followed by auditory discrimination tasks. These, too, require that the children have a fairly adequate knowledge of vocabulary. Conversely, 92% of all the children tested scored at age level or above on the gross motor assessment. The weakness in language skills and strength in motoric skills may be indicative of their particular environmental and cultural experiences.

Complete data regarding health and psychological concerns was obtained on 348 children from 84 families. The partial data available on the remaining 74 children from 24 families tends to reflect the same basic pattern of health concerns. Fifty six (16%) of the 348 had major health problems as follows:

21 (38%) exhibited some psychological disturbance (diagnosed emotional disturbances, mental retardation and/or learning disabilities),
8 (13%) exhibited a lack of speech,
6 (11%) were diagnosed as having active tuberculosis,
6 (11%) had a history of respiratory ailments (asthma, pneumonia, etc.),
4 (7%) were diagnosed as having acute lead poisoning,
3 (5%) had suffered from incidence of toxin ingestion,
2 (4%) exhibited speech and hearing impediments,
2 (4%) were diagnosed as having cerebral palsy,
3 (5%) were diagnosed as having macrocephaly, and
1 (2%) was born with drug addiction symptoms.

Social history

Social history secured on 256 school-age children, ages 6 to 17 years, showed the following incidences of problem behaviors:

46 (18%) were found to have truancy problems,
14 (5%) had been charged with delinquent behavior,
3 (1%) had been sent to a training school or youth home due to delinquent behavior, and
193 (76%) had no reported incidence of serious problem behavior.

There were no reported incidences of substance abuse.

Information regarding health, school, and social problems, as available to PACT in the initial data collection, proved to be understated or underreported in the light of subsequent knowledge of the children.

Descriptive Statistics of Services

PACT's program is composed of direct services which include all intensive home visiting and auxiliary services. The number of hours spent in all direct and auxiliary services during the 15 month period between June 1, 1977, and September 30, 1978, totalled 46,746, as indicated in table II:3.

Initial, Intensive Visiting

Initial Visits

During the 15 month service period, a total of 116 initial visits were made to referred families, out of which 108 were accepted for service and 8 were rejected. On the average, 2 hours per visit were expended, resulting in a total of 232 hours for this service.

Intensive Visiting

A total of 32,400 service hours were spent in visiting clients, telephoning resources on their behalf and recording casework activities for the total caseload serviced. This figure can be further broken down into

12,960 hours—spent in home visiting
6,480 hours—spent in telephoning
12,960 hours—spent in documentation

It must be noted that some families, i.e. those that have more pressing and urgent problems than others may require as many as 5–6 hours per week in home visits as opposed to those families whose needs are not as urgent, either due to the family's specific structure and/or the possibility that they are now being prepared for future termination from the project's active caseload. These families may only require one hour per week (or biweekly) of home visits.

Auxiliary Services

PACT's auxiliary services include parent workshops and corresponding child care facilities, surrogate siblings and parent programs, home repairs, moving services and donations, mental health consultation and the newsletter. (See previous description of the project for further elaboration of these components.)

Parent Workshops and Child Care

From August, 1977, to September, 1978, an approximate total of 124 parent workshops were offered in four separate sessions (one workshop per week for 4 weeks, two workshops per week for 36 weeks, and 3 workshops per week for 16 weeks). A total of 52 parents, or 48% of the 108 families enrolled in PACT, attended the workshops ranging from 1 to 26 times. The average attendance rate was 8 times. Service hours spent in conducting the workshops were approximately 500 hours with 900 hours spent in transporting clients to and from the workshops.

In terms of child care services, child care was provided during every workshop

Table II:3 Descriptive Statistics of Services

Type of Service	*Duration of service*	*No. of total service occurrences*	*Total no. of service hours*	*No. staff people*	*No. people served*	*Other*
Initial visits	15 months	116	232	2–3	116 families	108-accepted 8-rejected
Intensive visits	15 months		32,400	10 counselors	108 families	
a) home visiting		1–3/week/family	12,960	"	"	70% of counselors
b) telephoning			6,480	"	"	time spent in
c) recording			12,960	"	"	intensive visiting
Parent workshops	14 months	124	500	2	52 parents	avg. attendance
a) transportation	14 months	124	900	1	52 parents	rate = 8 times
b) child care	14 months	124	7,440	3/session	10/session	
Surrogate siblings	13 months	1–2 visits/week/child	2,080	9 (4 are PACT counselors)	14 families	
Surrogate parents	5 months	1–3 visits/week/family	200	3	5 families	
Donations	15 months	1–2 trips/week for donations	1,000	2	42 families	
Home Repairs	7 months	24 home repairs completed	448	2	12 families	
Moving Services	9 months	8 moves	120	2	7 families	
Mental Health Consultation	9 months	20–30 hours/week	1,000	1	10 counselors	
Newsletter	7 months	1 newsletter/month	280	1	professional community at large	
Developmental Assessments	15 months	73 assessments, 2 hours each	146	2	73 children	

session. An average of 10 children attended every workshop session with an averge of 3 child-care aides attending the children. Therefore, 7440 service hours were expended in this service.

Surrogate Siblings/Parent Programs

As of September 30, 1978, 14 families had been assigned to 9 surrogate brothers and/or sisters (4 of which were PACT counselors). The siblings spent approximately 8 hours per week with their assigned children over 52 weeks, resulting in 2,080 service hours.

In the surrogate parent program, 5 families were assigned surrogate parents and 3 parents were employed as such. The parents spent, on an average, 10 hours per week performing their assigned duties over a 5 month period, resulting in an expenditure of 200 service hours.

Donations, Home Repairs, and Moving Services

1. *Donations*

As of September 30, 1978, 42 families had received donations of furniture, clothing, appliances, etc. from PACT. These donations were generally distributed once a week during an 8 hour period over the 15 month duration, utilizing 2 staff members. Therefore, approximately 1,000 hours were spent in this service.

2. *Home Repairs*

Home repair services were initiated in March, 1978; as of September 30, 1978, a total of 12 families had been serviced with a total of 24 home repairs completed. Home repairs were generally done once a week during an 8 hour day, utilizing 2 staff members, over a 7 month service period, resulting in approximately 448 hours spent in this service.

3. *Moving Services*

Household moving services were instituted in January, 1978, utilizing 2 staff members who moved 7 families for a total of 8 times (one family moved twice). Within the 9 month period, the service hours spent amounted to 120.

Mental Health Consultation

A mental health consultant was hired in January, 1978 to advise the PACT counselors in the proper handling of any mental health problems that arose in their assigned families. The consultant spent 20 to 30 hours per week in this activity for a total of 9 months, resulting in approximately 1,000 service hours expended.

Newsletter

The first edition of the PACT newsletter was published in March, 1978. One editor spent approximately 10 hours per week researching and writing material, typing and laying out the copy, compiling mailing lists and mailing the finished products. Therefore, over the 7 month period, approximately 280 service hours were spent in this auxiliary service.

Developmental Assessment Services

A total of 17 infants, aged 0–2½ years, and 55 children, aged 3 to 12½ years, were assessed by developmental examiners at PACT's offices to determine their developmental strengths and weaknesses (see Description of Population Served for results

of these examinations). The examinations were approximately two hours in length for each child; the total number of service hours expended was 146.

Summary

The following points are highlighted:

1) Fifty-one children out of 110 originally in foster care were returned to their natural parent(s) after at least two months of service.
2) One hundred and ninety seven children out of 214 originally at risk of placement remained at home after at least two months of service.
3) The leading reasons for placement of children were physical, medical and/or educational neglect.
4) Among 60 terminated families, 47 evidenced progress towards stabilization.
5) Thirty-nine out of 48 active families were in the process of achieving stability.
6) Between June 1, 1977, and September 30, 1978, the PACT staff extended a total of 46,746 hours in direct and auxiliary services.

PART II B
Evaluation of PACT's Intervention Procedures for a Four-Month Period

Paul T. Giblin and Lawrence L. Biasatti

This section reports a study of alterations in the personal and social adjustments of a representative sample drawn from the total 108 families served by PACT from June 15, 1977, to September 30, 1978. It also reports the evaluative skills, allocation of time, and varying degrees of success for the PACT counselor teams.

Selection and Characteristics of Sample Families

The sample selected from PACT's total service population included fifty-one families. The only distinction made between these families and the rest of the service populations was that at least one child had to be living at home during the four-month evaluation period. Families served by PACT in February, 1978, and to whom at least four more months of service contact was anticipated, are included in this sample; families brought into the program between February and April, 1978, are also included. Evaluative termination of these families occurred between June and August, 1978, depending upon date of intake. In other words, while each sample family was studied for a four-month period, not all families began and ended on the same date. The families were visited at their homes and at other locations, such as social services agencies and foster homes, by the PACT counselors during the evaluation period.

Thirty-eight of the families are Black, twelve are Caucasian, and one is Hispanic. Eighty-six percent are single-parent households with only the mother present. These families include 204 children ranging in age from 0 to 16; 66 are aged 0 to 5, 78 are aged 6 to 12, and 60 are aged 13 and over. Only seven families report any income from salaries or wages. The remaining forty-four rely totally on some form of government assistance.

Evaluation Criteria

Evaluation of the alterations in the personal and social adjustments of the sample families is based on the considerations summarized below.

Ongoing or impending foster-care placement (as assessed by the PACT Admission Forms) among the PACT program's families is generally due to abuse or neglect of the children or to the presence of chaotic conditions (caused by substance abuse, mental illness, conjugal discord, etc.) which forestall adequate child care. Therefore, the variables chosen for evaluation reflect the concerns of professionals as expressed in extensive abuse and neglect literature (Elmer and Gregg, 1967; Spinetta and Rigler, 1972; Starr, in

press). Programs similar to PACT, such as the Lower East Side Family Union (Weissman, 1978) have also suggested points of evaluation. These points, which correspond to a number of the goals of the PACT program described in the Agreement to Purchase Services, are:

1. helping to organize and maintain a home environment sufficient for the growth and development of children
2. aiding the parents in understanding the needs of their children
3. fostering the parents' adoption of socially acceptable management techniques for their child(ren)
4. helping to develop a wholesome, stable family life characterized by such qualities as increased parental self-sufficiency and improved social adjustment of the child(ren)

The present evaluation reflects the adoption of an interactive model of abuse and neglect (Garbarino, 1977; Starr, in press) in which there is an examination of environmental, interpersonal, parental, and child factors.

Previous studies based on similar populations (Elmer, 1977; Giblin, Starr, and Agronow, 1978; and Relich, Giblin, Starr, and Agronow, 1978) have indicated that the assessments do not necessarily provide distinctions between families with different histories (for example, between those with a history of child abuse compared to those in which child abuse is not evident) or between families involved in different treatment programs. Distinctions, however, are found within and between these subsamples of the total populations when the samples are further defined in terms of various environmental, demographic, and parent and child attitudinal and behavioral factors. Previous studies of foster-care placement have indicated that relevant distinctions by which homogeneous subsamples may be formed include: age of the mother at placement (Jenkins, 1967; Jones, Newman, and Shyne, 1976; Podell, 1973); mother's ethnic background (Jenkins, 1967; Jones, Newman, and Shyne, 1976); number of children in the family (Podell, 1973); mother's attitude toward her child(ren)'s return (Podell, 1973); and the quality of the relationship between the client and worker (Podell, 1973). An extensive report of the status change of children in a five-year longitudinal study (Fanshel, 1976), describes further distinctions between and within subgroups formed on the basis of the child(ren)'s age(s) at entry into foster care, child(ren)'s sex and legitimacy or illegitimacy, and the reasons for placement. The present evaluation, therefore, includes change scores for both the total sample and for subgroups formed by these and other distinctions. The purpose of these comparisons is to identify those subgroups in which PACT's present program is most successful in bringing about change, and those which are currently beyond its scope.

Data Instruments

As a concomitant of its service program, PACT employs an extensive series of data instruments designed both to aid intervention procedures and to evaluate their success. Table II:4 presents the instruments used for evaluation, along with their time, place, and agent of completion. Items with asterisks are those primarily relied upon in the present evaluation and are more fully described below.

The evaluative instruments include the Child Social Adjustment Scale, the Inventory of Home Stimulation, three subsections of the initial and terminating Parent Interviews (the

Table II:4 PACT Evaluation Flow Chart

Form	*When completed*	*Where completed*	*Who completes*
1. Client Referral Form	First knowledge of client	Dept. of Social Services (DSS) or PACT office	PACT staff[a]
2. Review of Social Service Record	Before initial visit	DSS	PACT staff
3. Consent Form	During initial visit	Client's home	Client, PACT staff, and PACT counselors[a]
4. Medical Releases	During initial visit	Client's home	Client, PACT counselors
5. *Initial Visit Data[b] Form, and Assessment of Family Strengths	Immediately after initial visit and up to three weeks later	PACT office	PACT counselors
6. *Daily Activity Record	Immediately after each contact with client	PACT office	PACT counselor
7. Case Narrative	Immediately after each contact with client	PACT office	PACT counselor
8. Problem, Strengths and Objectives Profile (Needs Assessment)	Following first four visits	PACT office	Initially PACT staff and PACT counselors; later only PACT counselors
9. *Admission Form	Immediately after initial visit and up to three weeks later	PACT office	PACT staff
10. Master File Card	Immediately after initial visit and up to three weeks later	PACT office	PACT staff
11. *Home Stimulation Inventory	Two–three weeks after initial visit; *also* at end of four months	PACT office	PACT counselors
12. *Child Social Adjustment Scale	Two–three weeks after initial visit; *also* at end of four months	PACT office	PACT counselors
13. Developmental Assessments	Three–four weeks after initial visit	PACT office	PACT testers[a]
14. *Parent Interview	Three–four weeks after initial visit; *also* selective sections at end of four months	PACT office or other designated site	PACT staff
15. *Monthly Assessments	One month after initial visit and each following month thereafter	PACT office	PACT counselors
16. Initial Monthly Reports	One month after initial visit	PACT office	PACT staff and counselors
17. DSS Monthly Updates	Each month following Initial Monthly Report	PACT office	PACT counselors
18. Social Service Evaluation	Two months after initial visit; *also* at end of four months	PACT office	PACT counselors
19. *Termination Report	At end of four months	PACT office	PACT staff and counselors

[a]PACT staff refers to supervisory personnel; PACT counselors refer to individuals and teams that actually worked with the families; PACT testers refer to part-time individuals hired and trained to perform developmental assessments only.

[b]"*" Asterisked items are those upon which the present evaluation is primarily based.

IE, Parent Attitude Inquiry, and the Self-Esteem Index), and the sixteen subcategories of the Initial Visit Form/Monthly Assessments. With the exception of some subcategories of the Initial Visit Data Form/Monthly Assessments, these evaluative instruments deal with behavioral and attitudinal change. Attitudinal and behavioral measures, while previously demonstrated to be sensitive to distinctions within populations, have also been found to be resistant to change. In compliance with our service goals, however, we felt such measures appropriate to our evaluation. Therefore, any change reported on these measures during the four months of evaluation should be given special attention.

Three further points about instruments and procedures should be noted. First, a number of the instruments—for example, the Child Social Adjustment Scale and the Inventory of Home Stimulation—require the selection of one child from the family to be the focus of their questions. For this purpose a "target child" is chosen from each family. The target child is currently living at home with his/her family and is the family member most at risk of placement. If a number of children in a given family fit this description, a speaking rather than a non-speaking child is chosen; if the verbal criterion is not sufficiently delimiting, a child is chosen at random. Second, while the data instruments include a Termination Assessment, this termination is only performed in an evaluative sense. Contact with a number of these families is still maintained. Third, the selection and/or development of the instruments followed a four-month pilot testing of various evaluative tools and procedures. For example, the problem areas and their subcategories in the Initial Visit Form/Monthly Assessments were derived from open-ended questions which indicate the prevalence and relevance of these distinctions. Fixed alternative procedures (e.g., present or not present, more or less, etc.) were adopted to facilitate ease of reporting and ease of coding.

Initial Visit Data Form / Monthly Assessments

The Initial Visit Data Form consists of sixteen categories in which problems may be evident. These categories include: parenting; parental independence; development in children; environment; health care; physical ailments in parents and/or children; mental health ailments in the parent; nutrition; finances; community resources; social services; education; conjugal relationsips; and foster care.

Each area includes a number of specific behaviors. For example, among the parenting problems are inadequate supervision of children, negative disciplinary control of children, lack of positive interaction between parent and child, and psychological, physical and/or sexual abuse. The presence or absence of these behaviors is noted and their severity rated. Behaviors which are noted on the Initial Visit Data Form are transferred to the first Monthly Assessment. The Monthly Assessment forms include the same problem areas represented in the Initial Visit Data Form. Again the counselors note the presence or absence of specific problems and rate their severity. Previous ratings are not indicated on the Monthly Assessment Forms, but if problems were noted in the preceding month which were not indicated on the Initial Data Form, the counselors include these items on the Monthly Assessments. Each subsequent Monthly Assessment reflects the number and severity of items noted the previous month.

Also included in the Initial Visit Data Form, but not in the Monthly Assessments, is an Assessment of Family Strengths. This form, using rankings from "excellent" to "adequate" on a four-point scale, assesses as strengths the same areas which the Initial Visit Data Form assesses as potential problem areas. In other words, "parenting problem areas" becomes "parenting strengths."

Daily Activity Record

The information recorded on the Daily Activity Record includes the time, location, and duration of each contact with each family. The amount of time spent in discussion of each of the problem areas previously specified in the Initial Visit Data Form or Monthly Assessments is also noted. This procedure makes it possible to assess the relationship between the counselor's perceptions of problem areas and the time spent in discussing them. Finally, activities performed, the condition of the environment, and the presence of any unplanned beneficial action on the part of the family are reported.

Admission Form

The information recorded on the Admission Form includes the following demographic data: family identification code; date of admission to program; mother's birth date; formal education, religion, race, and marital status; referral source; place and owner of family's residence; members of family in the residence; parents' employment status; and family's source of support and annual income. A second component of this form includes the present legal status of each child in the family and the number, duration, and reasons for prior foster-care placements. In addition, any psychiatric problems, drug and alcohol abuse, crime involvement and/or imprisonment are noted for each parent.

Home Stimulation Inventory

Caldwell's Home Stimulation Inventory (Caldwell, Heider, and Kaplan, 1968) provides a measure of the social and physical environment of the target child. Specifically, it assesses: the mother's functional and verbal responsivity; her avoidance of restriction and punishment in handling the child; the adequacy of her organization of the child's physical and temporal environment; her provision of appropriate play material for the child; her involvement with the child; her provision of opportunities for variety in the child's daily stimulation.

Child Social Adjustment Scale,

The Child Social Adjustment Scale designed by the evaluation team for the purpose of this study, involves four dimensions: the target child's peer relations, family relations, emotional development, and relationships with his/her teacher and other adults in his/her own family. A number of specific items are included in each dimension and are ranked in terms of frequency (rarely, sometimes, often).

Parent Interviews

The Parent Interview includes three sections on both the initial and terminating forms: the IE (Gurin, Gurin, Lao, and Beattie, 1969) is a measure of the mother's perception of her control over events which affect her life; the Self Esteem Index (Bachman, Kahn, Mednick, Davidson, and Johnston, 1967) is a measure of self-esteem and positive feelings about self; and the Parent Attitude Inquiry (Baumrind, 1971) is a forced choice inventory composed of three dimensions of self perception (early maturity demands, anger over lack of control, authoritarianism). The initial administering of this interview also includes: a medical history form that evaluates the health history of the family; the mother's perception of her own parents; the mother's feelings about prior foster-care placements of her children if applicable; and the mother's perception of the extent and justifiability of punishment she experienced as a child. (In appropriate instances, fathers rather than mothers were interviewed.)

Termination Report

The Termination Report contains three sections. The first assesses demographic items which are the same as or similar to those in the PACT Admission form. The second section includes the PACT counselor's assessments of the primary cause of termination, recommendations for future placement of the family's children (i.e., with natural family or other), and perceptions of the family's current status when compared to other families serviced by PACT. The nine areas in which the family's current status is assessed include:

1. ability to organize and maintain the home environment for growth and development of the child(ren)
2. knowledge and skill in low-income budgeting
3. sensitivity to the child(ren)'s changing needs
4. utilization of socially acceptable management techniques
5. adequate and appropriate disciplinary control of the child(ren)
6. nutritional health standards
7. medical care (use of community health resources)
8. awareness and use of nonmedical community resources
9. the safety, cleanliness and organization of the physical environment.

In the third section, the total effect of PACT intervention on the well-being and functioning of the family is ranked.

Inter-rater Reliability

Due to the service demands of the PACT program, separate and independent reporting on all of the evaluative measures is impossible. However, families are contacted by two-person teams of counselors, and evaluation is a collaborative effort of these team members. Such a collaborative effort, in which independent judgments and ratings are compared, discrepancies are discussed, and a final pooled or average score is assigned, usually enhances reliability (Murphy, Murphy, and Newcomb, 1937; Sellitz, Wrightsman, and Cook, 1976). The advantages of this discussion procedure are enhanced by the monthly meetings of PACT counselor teams with supervisory personnel in which individual cases are reviewed.

Results

The results of PACT's present intervention procedures are described below for both the sample fifty-one families and for the subgroups of this sample formed by the introduction of moderating variables. On both levels of analysis, assessments focus on family, individual mother and child, and PACT counseling team variables.

Three points will further clarify the presentation of these results. First, the present evaluation is not an experiment: no comparison was made between a treatment and nontreatment group. Second, as previously noted, the behavioral and attitudinal measures which are chosen to assess this population at the beginning and end of the evaluation period are expected to be resistant to change; therefore any change occurring on these measures in either the total sample or subgroups is of increased significance. Third, the present report is a summary of findings which attempts to identify trends and general

conditions. Readers desiring a more detailed and statistically oriented presentation of data instruments and results may request "PACT Evaluation Data: February to August 1978" from the PACT program.

The dependent variables by which the effects of the PACT service programs are assessed are those included in the Child Social Adjustment Scale; the Inventory of Home Stimulation; the IE, Parent Attitude Inquiry, and Self Esteem Index included in the Parent Interviews; and the Monthly Assessments.

Assessments of Change and Intervention Procedures for the Total Sample Population

T-tests compare initial and terminating scores on all dependent variables with the exception of Monthly Assessment variables. Differences are not significant.

Repeated measures analyses of variance compare the number and severity of problems reported in each problem area on the Initial Visit Data Form and on the four Monthly Assessments. Generally, a decrease in the number and severity of problems is noted. Specifically, there is a decrease in the number and/or severity of problems noted by the counselors in the areas of parental lack of independence, parenting problems, adequacy of the home environment, and the availability and use of community resources and social services. The parents at termination of the PACT service are seen as being better able to relate to and manage appropriately their child(ren); they are able to provide a more wholesome and stable environment in which their child(ren) may develop and grow; and they are better able to manage their own resources and those of their community. The single exception to this trend is the number of problems noted in the area of conjugal discord. Perhaps these problems become increasingly evident to the counselors as a function of prolonged contact.

Decreases in the number and severity of problems are generally most evident in the first two months of assessment; there usually is no further improvement in the final two months of evaluation. However, the original gains are maintained. As noted by Polansky, Hally, and Polansky (1975), continued contact with the family after such gains forestalls regression and helps consolidate progress. Nevertheless, an important question for further study concerns the optimal duration of intervention. It now seems that the length of service contact after gains have been achieved should be varied within future service populations.

A concluding assessment involves the correspondence between the PACT counselors' allotment of time to each problem area and their evaluation of the severity and number of problems within each area. This assessment tests the adequacy of the PACT counselor teams' allocation of their time in relationship to their perceptions of family needs. Significant positive correlations are found between the amount of time spent in a given area and the number and/or severity of the problems in twelve of sixteen possible comparisons. The highest degrees of correspondence (correlations of .34 and .58) between counselors' perceptions of problems and their allocation of time occurred in the areas of development of the children; health care; physical health ailments in the parents; physical health ailments in the children; mental health ailments of the parents; and delinquency of the children.

Assessments of Change and Intervention Procedures for Subgroups Formed by Variables Present at the Beginning of Service

As was previously pointed out, the behavioral and attitudinal measures employed in the present evaluation are resistant to change. Further, if change does occur, it is most likely to be evident in only certain subsections of the evaluation population. For

example, a previous study (Fanshel, 1976) involving a service population similar to that of the PACT program reports that older children return home from foster-care placements in greater proportions than do younger children. Such divisions within the evaluation population would more adequately allow the assessment of change and also would identify those families PACT's service programs are most likely to help. Therefore, a large number of variables were introduced. Change in all the dependent variables are assessed by analyses of variance which compare the means of the subgroups formed by these moderating variables. A number of significant comparisons are found on various dependent variables.*

1. The severity and incidence of the parent's history of physical illness provides a number of significant comparisons. Those families in which the parents are most healthy evidence the greatest gains over the four-month evaluation period in terms of gains in the child's emotional development, in the adequacy of the child's relationship to teachers, in the mother's use of appropriate disciplinary techniques, and in decreases in parenting problems and financial problems.
2. Three age groupings of target children were formed: 6 to 13, 3 to 6, and less than 3 years of age. The older the age of the target child, the more positive the change in a number of areas. Interestingly, differential degrees of change are generally most evident in areas not directly measuring change in the target children themselves. For example, gains in the mother's self-sufficiency and decreases in her mental health ailments are most evident in families with an older target child. Further, the families with older target children have more adequate nutrition and income and make more adequate use of social services and community resources. Obviously problems associated with younger children are more resistant to change in the course of service contact.
3. The quality and kind of residence at initial contact also provides significant comparisons on a number of dependent variables. Those families who come from the most adequate residence, specifically, a single family home, demonstrate the greatest gains in the child's social adjustment and the mother's organization of the home environment. The children demonstrate more adequate peer relations and relationships with teachers and other nonfamily adults, and the mothers provide a greater number of appropriate play materials and an increased number of opportunities for daily stimulation. Further, decreases in problems associated with lack of parental independence, health care, mental health ailments in the parents, nutrition, finances, use of community resources, child delinquency, and conjugal discord are most evident in those families with the most desirable residence.
4. Source of income provides further significant comparisons on dependent variables. One group of families derived all their income from public assistance, while another group provided at least some of their own support. No significant difference existed between these two groups in terms of total family income or per capita income. Families that provide at least some of their own support, however, demonstrate the greatest gains in changes in the target child's peer relations, the mother's functional and verbal responsibility, her organization of the physical and temporal environment, and in reducing the severity and number of environmental problems and physical health ailments of the parent.

*All assessment of change between initial and terminating measures took into account the level of the initial score. Therefore, success in bringing about change is not confounded with the initial level of performance on these dependent variables.

5. A number of significant comparisons on dependent variables occurred as a function of the total time all the children in a given family had spent in prior foster-care placement. Consistently, those families in which no prior foster care had occurred demonstrate the most positive change of the four groups compared: no prior placement; placement for 1–11 months; 15–36 months; 37–204 months. Dependent variables in which this change is evidenced include improvement in target child's relationships with teachers and other adults; in three categories of mothers' organization of the home environment (avoidance of restriction and punishment, organization of physical and temporal environment, and involvement with the target child); an increase in mothers' self-reliance; and a decrease in mothers' use of authoritarian means of discipline. Further, this same group displays the greatest decrease in the problem areas of lack of parental independence, health care, education, and conjugal discord.

Other moderating variables do not form subgroups that differ significantly. These include severity of family isolation; presence of mental health ailments in the parents; parents' feelings about their parents; mothers' ages; mothers' marital status; number of children in foster care; and average number of visits and average time spent each month with the family. Although earlier studies have found that most of these variables distinguish between subgroups formed from populations similar to the PACT sample, these studies assessed status change of the children rather than change in attitudinal or behavioral measures. The latter set of variables seem more resistant to change and therefore our results seem unique and of increased significance.

Subgroups Formed by Variables Dependent Upon PACT Counselor Ratings

At evaluative termination, the PACT counselors are asked to describe the primary cause of termination and to rate each family on its ability to provide a wholesome and stable environment for its children. Families are rated as either good or poor in comparison to other families in the sample. Our concern is to see if these dichotomous global evaluations are sensitive to changes measured by our dependent variables. Consistently, in five different categories of evaluation, PACT counselors successfully identified those families that showed the most positive change as measured by our dependent variables. These categories include:

1. mother's ability to organize and maintain a home environment suitable for the growth and development of the child
2. mother's sensitivity to the child's changing needs
3. mother's use of socially acceptable management techniques
4. mother's attainment of adequate and appropriate disciplinary control of her child
5. mother's ability to meet adequate nutritional health standards for her family

PACT counselors also make an overall rating of the effect of intervention on the well-being of the family: none or slight positive effects; moderate positive effects; very positive effects. Further, they indicate the primary cause of termination for these families: child successfully placed with natural family/no further risk; child in other permanent placement; family discontinued or refused service. Both of these global evaluations provide a number of significant comparisons on our dependent variables. These comparisons show that those families with the highest PACT counselor ratings demonstrate the most positive change during intervention.

The PACT counselors' abilities to parcel out significant groups with reference to the dependent variables drawn from the Child Social Adjustment Scale, the Inventory of Home Stimulation, and the Parent Interview may be summarized in the following three points.*

1. The two global evaluations identify groups which differ significantly on gains noted in: target children's family relations; mothers' functional and verbal responsivity directed toward their children; mothers' ability to organize the physical and temporal environment so that it is appropriate to their children's needs; and mothers' involvement with their children. All comparisons show that the most highly rated families demonstrate the most improvement on these dependent variables.
2. Differential change in the mothers' functional and verbal responsivity is successfully predicted by all seven PACT counselor ratings. All ratings correspond to the direction of change in mother's responsivity.
3. Positive changes in the target children's peer relations correspond to positive counselor evaluations of the families in terms of: mothers' ability to organize and maintain the home environment for the growth and development of the children; mothers' sensitivity to the children's changing needs; and mothers' use of socially acceptable management techniques.

Subgroups Formed by PACT Counselor Teams

Five two-person counselor teams provided the services rendered to the fifty-one families of the total sample. Significant differences exist among those families served by different PACT counselor teams in terms of the changes evident on the dependent variables of the mother's feelings about her own efficacy and the target child's peer relations, and the final monthly assessments of developmental problems with the child, mental health ailments of the mother, financial problems, conjugal discord problems, and total problem severity. The team which reported the lowest number of average visits to their families over the four-month period (12.8) and employed the fewest intervention techniques showed the poorest results in terms of reported beneficial change in their families. On the other hand, the families served by that team which had one of the highest average number of visits (21.1) and employed the greatest number of intervention techniques showed the greatest gains. It is not clear from this data whether the specific techniques employed are responsible for these gains or if the use and reporting of a large number of intervention techniques is a measure of team investment in the families.

Discussion

As expected, no significant changes occurred between initial and terminating assessments for the *total sample* on the dependent variables derived from the Child Social Adjustment Scale, the Inventory of Home Stimulation, and Parent Interview. However, a number of significant changes for the total sample are indicated by PACT counselor ratings of the number and severity of problems for these families. The counselors

*These counselor ratings were also quite successful in distinguishing significantly different subgroups in terms of the number and severity of problems reported monthly. Since both these ratings are derived by procedures similar to termination assessments, however, they are not sufficiently independent to warrant discussion.

perceive positive changes in mothers' parenting skills and self-esteem, the families' total environment, and the families' ability to deal with community resources and social service.

Moderator analyses reveal that the beneficial effects of the present intervention are most noticeable in those families in which the parents are healthier, the home environment is more acceptable, the families are more economically independent, and there is less evidence of a prior inability to maintain a suitable environment for their children. Further, these distinctions between families correspond to a wide range of changes in our dependent variables. For example, the age of the target child seems to have the greatest effect on the mother's feelings of self-worth and her ability to meet the needs of her family. Such wide-ranging implications seem to support the adoption of the interactive model (Garbarino, 1977; Starr, in press) in which environmental, interpersonal, parental, and child factors are all assessed.

According to PACT counselor ratings of change in problem areas, the first two months of contact seem to account for the majority of beneficial change evident in the sample families. Further contact provides little beneficial change. One might question, however, whether the improvements noted in the first two months would be maintained without prolonged contact; further contact might consolidate these gains.

PACT counselor ratings at termination successfully formed subgroups from the total sample which differed significantly on a number of dependent variables. In fact, the ratings are so successful in distinguishing between families which had most improved during intervention and those which showed the least gain that perhaps an expanded and modified version of this format, with monthly application, might serve the major evaluative goals of this or similar projects.

To some extent for the total sample population, and to a greater extent for certain subgroups of this population, PACT's intervention procedures meet the goals described in the initial Agreement to Purchase Services. Specifically, gains were noted in:

1. parents' organization and maintenance of a home environment sufficient for the growth and development of their children
2. aiding the parents in understanding the needs of their children
3. fostering parents' adoption of socially acceptable management techniques for their children
4. developing a wholesome, stable family life characterized by such qualities as increased parental self-sufficiency and improved social adjustment of the children

The evaluation procedures also provide distinctions between subgroups in the sample population which correspond to greater or lesser profiting from PACT's intervention. Finally, the procedures of evaluation themselves demonstrate the feasibility and profit of such ongoing assessment.

PART III

Conclusions and Implications

Conclusions and Implications

Esther Dean Callard

The major implication to be drawn from Part II of this manual, the anecdotal excerpts taken from PACT files, and the evaluation conferences between counselors and staff is that PACT is providing a valuable service to its funding agencies. The project is responding directly and effectively to the recommendations of the 1976 State Child Care Study Committee on *The Needs of Children in Michigan* for

> programming and service through comprehensive, coordinated and flexible efforts; comprehensive interpreted as services directed at the entire life system of the child and family, not at fragmented characteristics; coordinated interpreted as open and flowing communication between service deliverers; and flexible interpreted as programs designed to fit the individual needs of children and families. (p. 11)

Distressed families, it has been shown, do respond to PACT's home-based intervention—*108 families, involving 422 at-risk or foster-care placed children, accepted service.*

The primary goals of the project are being met at a level beyond that reported in the literature for similarly distressed families not receiving special service.

> Children and parents are kept together
> *—92% or 197 children, indicated at-risk, remain at home.*
> Children in foster care are reunited with families
> *—46% or 51 children were returned.*
> PACT is able to document the need for permanent placement where that is in the best interest of the child
> *—for 25 children in 14 families such documentation, after intensive work with the families, was provided to the social service worker.**

The specific goals are being met.

> The parents at termination [of service] are seen as being better able to relate to and manage their children; they are able to provide a more wholesome and stable environment in which their children may develop and grow; and they are better able to manage their own resources and those of their extended community. [Giblin-Biasatti, Part II of this manual]

On the basis of its performance PACT is being funded for another year. Although its basic goals and specific objectives remain the same, the Giblin-Biasatti evaluation has indicated the need to reconsider certain policy and procedural practices and to plan for the augmentation of those aspects of service which have proven to be particularly effective.

*Figures are based on 99 families with 324 focus children who received at least two months of service.

Selection of Clients

The implications which may be drawn from PACT's record of success or failure as a function of the clients' characteristics are less than clear cut. The data indicate that the project's success is greatest with the families who have the fewest problems and the largest resources at the outset.

In reviewing PACT's rate of success data, there appears to be justification for confining PACT's services to families who do not exhibit excessive financial and personal problems. On the other side of the argument, it may be contended that whereas a relatively intact and resourceful family will often survive without the kind of intensive service PACT offers, more disorganized, financially depleted families will almost certainly move into deeper disintegration if left without assistance. Jenkins (1975) discusses the client-selection problem:

> The social work profession needs to cope with the finding that clients in better circumstances, with more strengths, make better use of help. Does this mean that more intensive work is needed for people with more severe problems, or does it mean that "quantity changes quality" and new directions and different service modalities are needed when multiple problems and client resistance are met? If this issue is not faced, the field will continue to give more to those who need less, and less to those who need more. The question may be raised as to whether scarce social work resources should not be put where the prospect of success is greatest. In practice, however, this has meant widening the gap between function and dysfunction, and allowing a pile-up of population groupings with severe deprivation. One further consequence is seen in client perception of services, e.g., the more problematic the situation, the less helpful are services perceived to be by the clients. (p. 141)

Two questions must be considered. The first question: Should PACT confine its services to the more distressed and financially depleted families? [assuming that existing services outside of PACT will furnish whatever supports the less-depleted families need for rehabilitation.] The answer is clearly "No." PACT's "upper-limit" families are still existing in overwhelmingly difficult conditions. The proof of this is in the fact that they have, indeed, failed to provide a wholesome environment and their children have been removed or are threatened with removal from the home. The existing services have not been sufficient to correct or prevent the separation of child and parent. With a home-based service, such as PACT's, the time and energy expended to get these families to an acceptable level of functioning may be minimal, but without it the cost to the child and to the community may be great.

The second question: Should PACT confine its services to the families with whom it has shown the clearest evidence of success? Certainly rate-of-success data would look more impressive if this path were followed. Case histories and staff experiences, however, argue in favor of rejecting such a policy. PACT is seeing substantial improvements in some families which, at the outset, presented a "hopeless" profile. Jones (1976) also discusses the client-selection problem in describing the outcomes of the New York State Prevention Services Demonstration Project:

> The findings of this project suggest that better results may be achieved quickly with young families, not burdened with chronic problems and severe pathology.

92

> No characteristic, however, augured strongly against good outcome, and service factors were highly important to outcome even after the effects of background and problem factors had been taken into account. We believe it would be a gross error, therefore, to confine preventive and rehabilitative service to the most promising cases. We recommend rather that the net be spread wide. Realistic goal setting and periodic evaluation of progress can then be used to decide whether the service investment should be continued, without the injustice of screening out initially the families whose own resources may be mobilized by a concerned and active counselor and who may be most in need of this "second chance." (p. 127)

At this point, it is the decision of the PACT staff that no family should be labeled "hopeless" if a social service worker has referred the family and if the family has agreed to work with PACT. Therefore, careful screening of cases at the outset is extremely important.

In its original client-selection criteria, PACT indicates that it does not have the resources to work effectively with mentally ill parents. However, experience demonstrates that it is not easy to deny service to such parents. Psychological distress is not a clear-cut entity that can be unfailingly diagnosed on the basis of past history or client interviews. It is a relative condition, an intermittent condition, and a potential condition for virtually every client.

Descriptive statistics on the parent's Social History reveal psychological disturbance of mothers in 28% of the cases; and in the parent categories leading to placement, mental illness accounts for 10% of the cases. Despite the frequency of mental health problems, which these figures and the case histories suggest are present, evaluation data did not reveal that "mental health ailments of the parents" constitutes a discriminatory moderating variable in predicting success. This may be due to the fact that, at the time of PACT service, psychological disorders are not sufficiently debilitating to interfere with the requisite level of functioning. Or it may be due to the appropriateness of PACT's specific treatment strategies and supports, i.e., the emphasis on worker-client relationships, and use of mental health consultants.

PACT will continue to screen out families at the outset where severe mental illness is an obvious factor in the child's at-risk status. However, it is expected that there will continue to be a need for mental health consultation and for psychological referrals for many of PACT's clients. Thus, efforts will be extended toward utilizing appropriate community agencies and services which render assistance with psychological problems.

Evaluation data also indicate that PACT service is least effective in eliminating problems related to conjugal discord. However, even when conjugal discord is present, improvements in aspects of the home environment and the child's well-being have been achieved. It does not appear possible or even desirable to exclude such families from service.

A basic criterion for PACT's acceptance of a family is the desire of the caregiver to retain his/her child and the willingness to cooperate with the service plan as expressed in the initial interview. Avowing an interest in cooperating with the project, twelve families accepted into PACT's service proved to be less than committed and either refused service or became unavailable to the counselors within the first few weeks of service. It may be that the process that Weissman (1978) calls "engagement" cannot be adequately determined during an initial visit. In the Family Union Project, Weissman refers to the initial visit as "the first step in the engagement process" (p. 65), and it is not until the worker and family have worked out goals (within one month or by the third visit) that it is determined

whether or not there is sufficient engagement to justify working with the family. It would seem that PACT has been premature in assessing commitment on the part of the family. PACT will consider a more prolonged "trial period" before classifying a family as "accepted into the program," and will look more intensely into the early indicators of eventual engagement.

Duration of Service

The question of optimal duration of intervention is a seriously debated issue within PACT's staff. Although statistical analysis indicates that families' problems tend to be reduced in number and severity after two months of PACT service, and that they do not thereafter show greater reduction, it is the opinion of the Principal Investigator and staff that such improvements are a function of the relationship of trust being established, at this two-month period, between counselors and family, i.e. a "honeymoon" effect. There is also a conviction that, should service be terminated at this peak period, any gains made would be quickly lost and the client would perceive this experience as yet another disillusioning contact with a service that promised assistance but didn't follow through. There is substantiation for this point of view in recent publications. Polansky, in his *Profiles of Neglect* (1975), summarizes numerous studies and concludes:

> One reason for long-term contact in the treatment of neglect is to ensure that gains made by a family are consolidated and likely to be sustained. Several authors warn specifically of the tendency in such families for repetitive regressions to less satisfactory child care after seeming advances have been made. Premature cessation of contact may be viewed by the family as abandonment. In any event, new patterns cannot be expected to remain firmly in place until they have become habitual. Therefore, any marked advance must be conservatively regarded: that is, hopeful but probably temporary. All experts agree that treatment and support should continue for months after the family has, on the surface, ceased to be neglectful. (p. 43)

Having expressed itself in favor of maintaining service to families beyond the point of initial improvement, PACT counselors and staff concede that early termination of service should be a goal that is thoroughly explored and utilized under appropriate conditions. More emphasis will be placed on setting target dates for terminations which are mutually agreed upon by parents and counselors. A monthly objective review of family status by an experienced PACT counselor, the case work supervisor, and the project director will continue as a regular feature of the monitoring system so that service is not continued to families who are beyond the point of service effectiveness. As is the case now, a plan for maintaining a reduced level of contact with the family, that is, a "tapering-off period" will be developed with the family prior to final termination of service. During this period, family members may continue with auxiliary services, such as the Parent Workshop. Whenever possible, existing community services will be utilized to provide support at a less intensive level of service than PACT provides. PACT will also attempt to work more closely with the assigned social service worker and to urge that termination of PACT service *not* imply termination of the family from the special protective service rolls.

PACT Service Emphasis

The most successful feature of the PACT project is, according to staff judgments and evaluations, and based on evidence from other studies, the combination of

1. a supportive relationship
2. direct service
3. modeling and re-education

It is difficult to separate the above features of PACT's intervention. As was emphasized in the Introduction, PACT's goal is to offer service and to provide education *through a relationship*. It is clear to the counselors that the services they provide, such as transportation to foster-care homes or help in finding better housing, while of undoubted value in themselves, are also important as demonstrations of the counselor's real concern for the parent and child(ren). This, in turn, is essential if the counselors wish to have their advice, teaching, or modeling behaviors accepted. Thus, it becomes an inter-dependent system, with relationships/service/education all reinforcing each other.

At the outset of PACT it was suggested that, for evaluation purposes, counselors should, at random and arbitrarily, choose a treatment approach stressing either relationship or direct service. Such a tactic was quickly rejected and will continue to be rejected until funds are available for research. PACT must continue to use all available resources in the manner most likely to effect the desired changes. At this point it is the judgment of the Principal Investigator and the staff that the client/counselor relationship is central to the process of remediation. PACT is reinforced in its emphasis on this relationship by findings reported in social work literature. Jones (1976) in her carefully controlled research found that the worker-client relationship had a higher correlation with achievement goals and favorable status of the child than any other of the independent variables examined as possible contributors to outcomes. She concludes:

> Of the aspects of service examined, a good relationship between client and worker was the most important predictor of good outcome. If the case-worker had professional training or several years of experience, the worker's principal role in interviews with adult family members was an active one of giving advice or arranging practical services, and all needed services were provided, the promise of positive outcome was enhanced. (p. 124)

An earlier home-based program targeted at "disorganized, socially maladjusted families" which had shown an inability to cooperate with social agencies, is described by Pavenstedt (1967). She writes of the mother's "initial distrust and suspicion" and the fact that these women are "overcome by a feeling of isolation." Pavenstedt states the need for education within a relationship:

> We learned that besides going out to these people in their homes, we had, in order to cross class barriers, to share personal experiences with them, exchange information about food and clothing sales, recipes, and our own attempts to deal with children. This sort of exchange allowed them gradually to feel genuinely accepted.

Polansky (1975) highlights and illustrates his summary of findings regarding the crucial role of worker-client relationship as follows:

> In view of the early identification made by England's Family Service Units of the importance of giving concrete help, it is instructive to read one of its recent papers. The paper describes the help that was successfully given to a family referred by its physician because of his concern that the children's health was seriously endangered by the family's disorganized way of life. Concerning the family's needs and the help it received, Halliwell (1969)* mentions the following principles: the need of an isolated family to gain and feel acceptance; the importance of giving any material or financial help within the context of a relationship (otherwise it is felt to be impersonal and encourages passivity); the importance of enabling the family to use resources by preparatory work on their anxieties and by accompanying them on referral; *continued contact long after signs of improvement occur,* lest the family regress; and contact that includes husband and wife jointly. A day care center, a clinic, even what we call an "old clothes room" were all used by the family described. But the key element, in Halliwell's opinion, was what we term "working within the relationship." (p. 42)

The implication for PACT service is clear: recruitment and training must continue to place high on any list of priorities the ability of the counselor to establish a warm relationship with PACT parents. In addition, there is need to operationalize the concepts "warm," "supportive," "strong" relationships so that daily assessment records make such relationships clear and their impacts on outcomes directly measureable.

A second feature underlying PACT's service delivery is *flexibility* (see Introduction). Experience suggests that flexibility should continue to be a cornerstone of the PACT philosophy. It was, and is, impossible to *predetermine* the nature and level of direct service which will best serve a PACT family. Due to budget and staffing flexibility, PACT administrators are able to construct appropriate service components according to revealed need on the part of the client and revealed lack of resource to meet that need in the existing social network. Quick response of service to need results in the kind of immediate alleviation or prevention of conditions which could worsen the plight of the family, such as the repair of broken windows or replacement of locks on doors. It allows experimentation in auxiliary services based on client's expressed needs and interests, such as the Parent Workshops. It permits workers to use their best judgment in providing a service which may be available only after considerable delay if procured through "channels" when immediacy is of utmost importance to the well-being of the child.

The effectiveness of prompt, appropriate service is apparent when one is trying to upgrade the care and environment of a neglected or abused child. The child does not wait in his development for applications to be processed or new services to become available. A secondary benefit is the increase in PACT's credibility and potency with the family. PACT can provide concrete evidence of its avowed commitments: cleanliness in the kitchen (bringing trash bags and joining the parent in clean-up); maintaining contact between the mother and the child in foster care or meeting clinical appointments (driving her there and back); helping school age children to establish contacts with appropriate models (providing surrogate siblings).

It can be argued that the direct, responsive service offered by PACT is fostering an illusion, creating dependency on a "fairy godmother" type of agency. This could indeed be the case if direct service were the extent of PACT's efforts, or if it were used indiscriminately. As utilized, however, service is directed toward the goals of eventual family reme-

[*Halliwell's 1969 paper is referred to as follows in Polansky's bibliography:] "Halliwell, R. 1969. "Time-
96 Limited Work with a Family at Point of Being Prosecuted for Child Neglect." *Case Conference* 15: 343–348."

diation, meaning the ability of the family to maintain a wholesome environment for the child once PACT service is terminated. Toward this end, flexibility in the type and level of direct service is indispensable.

Certain aspects of PACT service originally not envisioned as part of the project have proven to be so valuable that provision for their continuance and coordination with other program components is clearly advisable. Among these components are the Parent Workshops, a demonstration-modeling childcare workshop, surrogate siblings and surrogate parents programs, and certain direct services such as home repair and moving. Reorganizing and coordinating these services will permit them to be integrated into service goals and will relieve the counselors of some time- and energy-consuming responsibilities.

If funds or outside agency support can be found, PACT should expand its policy of offering the Parent Workshops for the mothers after case termination. Sherman (1974) speaks to the need for such follow-up service:

> Finally, the findings from followup interviews with families of children discharged from foster care indicate that the well-being of the children is enhanced by the return and that followup services after discharge are crucial to prevent return of the child to foster care. The services that seem most needed are help with problems of income and housing, and the sustaining emotional support and interest of workers responsible for the case. To deny these aftercare services in many instances would risk unnecessary return of the child to foster care and perhaps the start of the all-too-common and destructive cycle of entry, exit, and reentry into foster care. (p. 104)

The mothers' acceptance of the Parent Workshops came as a surprise to some of the staff, including the Principal Investigator. Published research consistently describes the characteristic response of mothers, such as those served by PACT, as being highly resistant to group involvements. Elmer (1971) contrasts the abusive versus the non-abusive mothers as follows:

> The most striking difference between the two groups was in the extent of associations outside the home. The abusive mothers belonged to few groups, such as church, PTA, a lodge, or a union, and had almost no close friends who might be companions or sources of help. Our impression was that it was the women themselves who resisted becoming involved in relationships, even when they might have done so. The same isolation was reflected in the absence of ties between the abusive mothers and members of the extended family. The majority stated that no adult on either side of the family could be depended on for help, should the need arise, while all the non-abusive mothers had someone in the extended family to depend on. (pp. 53–54)

PACT's success in involving some mothers in the workshops is probably due to the already established relationship with the counselors. Once in the group, although some mothers initially tend to ward off any close contact, there is often a coming out of isolation and a sharing that is obviously extremely significant to them. The attendance records demonstrate this clearly.

Professional Orientation

In the Introduction, it is pointed out that one of PACT's unique features is that it is based in the academic discipline of Child Development and Family Relation-

ships within a university department which stresses the concept of the family as an ecological system. The problems of the neglectful families treated by PACT have proven to be problems uniquely served by the training and abilities of persons in this child/family/home management oriented curriculum.

PACT workers have shown they are able to meet the specific goals relating to child care, nutrition, budgeting, and improved home environment because they have the academic and the practical background needed to solve problems and model appropriate behaviors in these areas. What they lack in their personal experience, they are able to supplement with consultation from faculty and advanced students in the Department of Family and Consumer Resources.

An even more significant aspect of the relevance of child development background for workers in this field is suggested by Polansky (1975). He discusses the need for persons with knowledge of child development to assess the child and his/her care if social welfare policies are to be justly and wisely constructed and administered. Lacking this knowledge, child custody becomes less than rational in terms of the child's ultimate welfare.

> There are dangers involved if the law removes children on the basis of uncertain predictions of things to come. Hence, judges generally confine themselves to matters of clear and present danger, whereas social workers become concerned about what the child's future will bring if nothing is done about the child's current circumstances.
>
> Certainly, the state of knowledge does affect what is regarded as neglectful. . . . Hence, a professional statement of what constitutes child neglect depends on our knowledge of child development in all its facets. (pp. 4–5)

PACT staff members are called upon repeatedly to bring professional judgment to this question of the adequacy of parenting and the developmental status of the child. The awesome responsibility of knowing that their opinions may have a role in determining the destiny of a child and a family has proven to be a strong impetus to the staff and the counselors to improve their knowledge of child development and their skills in assessing the quality of caregiver-child relationships. Vague generalizations such as, "the child's needs are being neglected," or "the mother is detached and rejecting" are insufficient descriptions. Definitions must be operationalized. Toward this end, specific parent-child interactions must be recorded, studied, and evaluated. Is a parent's "abusive" language conveying feelings of scorn and inflicting psychic wounds? Or is it voicing concern? And is the concern perceived by the child as evidence of parental love? Is a father's denial of his son's delinquent behavior, in the face of blatant contradictory evidence, providing support to the boy; or is it tantamount to utter rejection? Judgments made on the basis of surface behaviors, particularly when they are behaviors derived from a population and a culture not completely familiar to the evaluator, can be erroneous. In the PACT service project there is an unique opportunity for the field worker and the child development educator to work together, comparing the "surface behaviors" to other indices and child outcomes and trying to derive valid interpretations of what is seen and heard.

A cornerstone of PACT's training and service model is its interdisciplinary aspect. Whereas the project is sponsored and administered by a department which emphasizes child development, family relationships, and home management, it has succeeded in its goal of incorporating consultants from various professional disciplines and works successfully with agencies representing a wide spectrum of vocational orientations. The home
98 counselors (actually students in the training program) also come from diverse educational

and experiential backgrounds. There are problems inherent in working with people from unfamiliar, or competitive, disciplines. These problems are being overcome by intensive and extensive cross-communication; by discarding professional "jargon" and translating theories and processes into operational terms; and by keeping uppermost in mind the service to the client, regardless of where or by whom that service is performed.

The multidisciplinarian approach operates and reaps benefits at various levels and stages throughout the PACT intervention process. First, it begins when the home counselor teams are formed. As described by the Project Director, there is an attempt to team students who have different but complementary backgrounds, for example, a child development student, who has had experience in working with infants and their mothers, with a student, whose degree is in education and who has worked with runaway teenagers. Such a team obviously brings more resources to a PACT family than one in which the counselors have had the same schooling and working experiences.

Secondly, the formal courses offered as part of PACT training have benefited greatly *from* input *from* social workers, health workers, lawyers, and educators. One of the obvious benefits has proven to be the insight and practical suggestions gained from these professionals which can be applied when the PACT workers encounter problems in working with these professions in the field.

Thirdly, there has been the benefit to our clients and to our student trainees of seeking assistance in the community from every and any source available, regardless of its professional origination. The trainees have had the opportunity to make contacts with private charitable organizations, educational programs, health agencies, and a number of social services. This exposure has vastly increased the educational horizons and professional expertise of both trainees and staff.

Finally, the opportunity for the staff to not only practice, but also to construct research in an interdisciplinary field study is rare and invaluable. Polansky says it well:

> there are many areas of social work research in which it is necessary to be a practitioner in order to sustain creativity . . . The ideal researcher, therefore, is either still in practice or lives very close to it. He knows the theory that guides practice and his research, and it is very real to him if he wants to contribute to "practice-theory." Many attempts have been made to substitute for this combination, since it takes so long for any person to acquire all the requisite experience and skills. The most familiar substitution is the inter-disciplinary team of researchers and clinicians. All now agree, alas, that the best integration in an inter-disciplinary approach seems to come from having two disciplines within a single skull. (S. W. R., 1975, p. 14)

Getting the two disciplines, Human Development and Social Work, within a single skull is one of the greatest long term benefits which is being reaped by the PACT personnel from involvement in this project.

Evaluation

In reviewing PACT's evaluation, we are also able to critique the evaluation process itself. In this first year of operation PACT has been fortunate in having the consultant services of members of the Human Development and Relations faculty and a computer programmer. Thus it has been possible to prepare the analysis reported by Giblin

and Biasatti (Part II of this report). This is a feature which, from the perspective of the Principal Investigator, is absolutely essential when an experimental program is undertaken. By carefully documenting service variables and outcomes and analyzing their relationships it can be determined what aspects of service are contributing to successful or negative results (Shyne, 1976). Thus there is a reasonable basis for continuing, eliminating, or modifying remediation strategies.

Unfortunately, with a service project such as PACT, the funding agency expects that service delivery will begin as soon as the funding begins. There is rarely any lead time to explore and perfect the data collecting procedures, let alone the total design of the evaluation. Thus, it was not until after approximately six months of service that the forms and procedures were ready for use in project evaluation. Not being certain what specific information was needed, the evaluation team decided to err in the direction of redundancy. As Giblin indicates, counselor summary assessments turned out to be in basic agreement with the data collected on the daily reports and it is clear that, in the future, the volume and detail of reporting can be streamlined without the loss of essential information. However, the counselors' experience in completing the daily reports was undoubtedly a factor in their ability to summarize problem/treatment/outcome sequences so accurately. The implication is that filling out daily reports should be a part of any new counselor training until some criteria of accuracy in summarizing is achieved.

Giblin reports that "modelling and reeducation" proved to be the most salient approaches used by counselors. This finding is not surprising; what is surprising is how seldom the counselors recorded using this approach in their daily reports. When reading prose accounts of client-worker interaction, and when discussing the families with the counselors, the supervisory staff has the impression that, in fact, modelling and reeducation occurs more often than recorded. It would seem that more attention should be paid to training the counselors in correctly identifying their approaches, and in addition, outside evaluators should periodically describe the workers' approaches while interacting with the family.

There is also an apparent need for outside evaluators to make assessments of initial, periodic, and terminal family status through direct observation and use of standardized measures. Additional instruments for pre and post assessments should be designed expressly for PACT, such as a parent questionnaire to ascertain how family status and service impact is perceived by the recipient of the program.

Although present PACT evaluation findings do not deal with the question, there is a likelihood that PACT could be used more effectively if case selection were targetted more specifically to the services provided. Light (1973) recommends:

> A controlled field study should compare the effectiveness of different strategies for dealing with parents already identified as abusive or neglectful. It is likely that interactions will be found, that different kinds of ameliorative strategies will be seen to be best matched with specific kinds of child maltreatment. A controlled field study will be more difficult to implement than a series of disconnected innovations. But a well designed study offers the most hope for learning what services will be most beneficial for families who maltreat children, and since the services being compared are vital, they should inspire rigorous attention to study design. (pp. 597–598)

A controlled field study is outside the province of a single service project. However,
 the need and the potential savings to the community on the one hand, plus the complex

problems involved in such research undertakings on the other, are well acknowledged by leaders in the field. As Shyne (1972) summarizes:

> The study of the nature and outcome of services to children in their own homes should indicate what kinds of services are likely to be associated with what kinds of outcomes, and so offer leads to the extension and strengthening of services to children in their own homes. (p. 573)

Relationship To Other Services and Agencies

A gratifying outcome of the PACT service is proving to be the harmony and mutual respect which characterizes the relationship between the protective service or foster care workers in the Department of Social Service, and the PACT workers. It did not happen overnight. There was, at the outset, some hesitancy and suspicion on both sides. This is natural, and probably inevitable, when a new service and/or agency enters the arena of an established system.

Polansky (1975) speaks pessimistically of the coordination between the responsible persons involved in child protection and placement, even without the insertion of yet another new and unknown entity into the picture.

> In order to maximize the possibilities of returning children to their own families, coordination is needed among the protective service worker who should be continuing work with the parents; the foster care worker, if different, who is supervising the child; and the court personnel if the court is still active on the case. It cannot be said that intimate collaboration is the rule in this country at this time. (p. 45)

At the outset of the PACT project, it was difficult to get protective services or foster-care referrals, particularly those that met the PACT criteria. Once PACT realized that its criteria had to be relaxed if the most needful families were to be served and took on these seriously *disorganized* families, demonstrating that PACT could serve the department, cases were referred at a rate beyond the capacity of PACT to respond.

Since PACT has worked closely with the Department of Social Services, it has been able to appreciate the problems encountered by the foster care and protective service workers. These problems fall into three major areas: preventive measures, community resources, and overwhelmed workers.

Preventive Measures

Under present legal and funding restraints, it is difficult for the various human service agencies and institutions, i.e. health, education, social service, to reach the right people in the right way so that the child neglect/abuse can be prevented. Elmer (1971) discusses this need:

> Remedial measures are difficult; they may involve the separation of the child from his family in order to protect him from serious injury or death. Obviously, such drastic treatment does nothing to alter the unhealthy relationships within the family, and it may even lead to the abuse of another child. Prevention is the more

> hopeful direction. Help during the child-bearing years might be provided by family allowances, as in most other civilized countries. This is one way of lessening everyday burdens and making room for the solution of other complex problems. Particularly vulnerable mothers might be identified through the prenatal clinic or the lying-in hospital; supportive measures and anticipatory guidance would be most meaningful during the pregnancy and neonatal period. Information about family planning needs to be available and clearly understood. (p. 57)

PACT has found that the mothers in the Parent Workshop are avidly interested in family planning and problems of childbirth. They are, however, woefully ignorant about their own bodies, the processes of conception, birth, and early infant care. We are dealing with these problems "after the fact" but, perhaps, should be more concerned with preventing a repetition of the cycle of unwanted pregnancy, inadequate prenatal care, and poor early mothering. This is a job that should be done in the public education system for, as Light (1973) points out:

> education in child development, an excellent idea in its own right, has not been shown to decisively affect the specific problems of abuse or neglect. Rather, family size data suggest that widespread family planning education might be more effective in preventing child maltreatment. (p. 595)

It is perhaps appropriate to point out that, at the time of this writing, the State of Michigan, although provided with the necessary permissive legislation, has failed to institute a single teaching program in family planning in its public schools.

Community Resources

The lack of community resources to serve families in ways that are realistically suited to their needs and their level of capacity to respond is the second major problem area. Gruber (1978) states:

> Preventing the placement of children presumes that the social workers have access to adequate resources. Large numbers of parents felt that alternatives such as homemakers, day care, and family counseling, would have prevented the necessity of surrendering their children. (p. 189)

PACT's experience indicates that good, accessible day care is a frequently encountered need that is hard to meet. Studies indicate that day-care experience, even for infants, is not *necessarily* injurious to the child (Caldwell [1970], Cochrane [1977], Kagan [1978], Keister [1970]). It should be kept in mind, however, that these studies often involve a well-funded, university administered, day-care facility and always involve systematic surveillance by the evaluators. In such situations there are acknowledged safeguards to the child. The admonition expressed by Polansky (1975) deserves to be heeded:

> Despite their high promise for making it possible to meet significant needs of very young children without removing them from their homes, disturbing reports about a few day care centers must be noted. Parents in low income neighborhoods who use day care so that both can hold jobs are vulnerable to exploitation by day care operators whose interest is nearly entirely financial. For example, two-year-olds have been found sitting in lined-up chairs—like comatose mental

> patients in a back ward—under orders to remain silent and "not to be a nuisance." Overcrowding, which has been observed, is tolerated in order to add to the operator's income.
>
> Thus, day care, like other well-intentioned social inventions, is susceptible to the corruptibility to which man is heir. We have been advised by those expert in this field that strict standards for licensing and constant supervision is necessary, and that such standards are readily acceptable to ethical operators of day care facilities. Would it not be outrageous if we found that we were tolerating a version of child neglect and subsidizing it with tax monies? (p. 48)

The advice usually offered to parents should be heeded by professionals as well: don't place a child in a day-care home or a center without visiting the facility, talking to the care-giver, and observing the children in the program at some length.

One inadequately met need clearly recognized by PACT workers is for respite homes, that is, foster homes that could accommodate a mother and her child. Such homes, patterned after the Lula Belle Stewart Center in Detroit, could be set up to insure not only a safe and well-ordered living space but also instruction and guidance in child care. The foster parents could provide a supportive relationship and a model for the mother. Such a protected therapeutic milieu, which could be operated without disturbing the attachment between child and mother, would be ideal for many of the young mothers PACT has served. If available within the neighborhood of the mother it could even encourage the establishment of contacts outside the home which would give ongoing support after the mother's departure from the respite home.

In its advocacy role vis-à-vis education PACT has identified three problems which are characteristic in the client population: the bureaucratic barriers a parent faces who finds need to place a child in a specialized educational program; the lack of educational programs to improve the skills of mentally retarded adults who parent mentally retarded children, and the more frequent unmet need for remedial education. Through both its counselors and surrogate siblings, PACT has tutored a number of children in order to bring them up to grade-level. While the concept of learning within the context of a supportive relationship is excellent, the need for remedial instruction far surpasses anything that a small agency can provide.

Concerning its input in the juvenile court, PACT recognizes the value of its knowledgeable documentation of cases. Yet the need for more legal expertise in the Department of Social Services is critical. Motivated by recognition of this need, PACT developed a proposal to improve juvenile court handling of child protective cases by addressing the need for legal counsel in the department. The proposal also endeavors to eliminate congestion in the court, streamline case processing, increase community awareness of court jurisdiction and procedures, and improve the relationship among the community, court and child protective services.

Overwhelmed Workers

The large case loads and lack of coordination of service combine to make the magnitude and complexity of the child protective worker's task overwhelming. Jones' (1976) findings suggest:

> Caseloads must be small (10–12 families) to permit close contact with families—nuclear and extended—and ample time for extensive work with other agencies and organizations. (p. 126)

It is little wonder that such small case loads are recommended when the complexity of the task is considered. As she states it:

> The difficulties of families in "negotiating the system" are enormous, especially in large metropolitan communities. Restrictive eligibility requirements, inconsistency of regulations across systems, and misinterpretation by staff of the complex rules within which they operate posed severe and often insurmountable problems even for experienced social workers in their attempts to assist project families in utilizing theoretically available services. (p. 124)

Or, as Polansky (1975) emphasizes, the task of bringing the parts together is best served by one comprehensive worker:

> Generally the caseworker is the link that puts the family in touch with needed resources, such as financial aid, services to improve housing, medical care, homemaker and other services. In dealing with the community and its agencies, the worker is a case-by-case child advocate. Without one person definitely responsible for this connective function most other services may as well be inoperative. (pp. 41–42)

Recommendation

If the PACT approach proves to be an effective and, in the long run, an efficient method of keeping parent and child together within a home that promotes wholesome development, its comprehensive, intensive, home-based service design may be a model that can be incorporated into the social service structure. If this occurs, it should be done with appreciation of the fact that certain features of PACT, integral to its design, may be the features responsible for its effectiveness. The PACT project incorporates:

a. administrators and counselors knowledgable in the fields of child development, family relationships, and home management;
b. an approach based on direct service and re-education offered within a warm, supportive relationship;
c. flexibility in funding, staffing, and programming that allows the service to be responsive to each family's needs and potentialities.

Appendices

APPENDIX A: PACT Project Roster

Department of Family and Consumer Resources

Wallace Williams, Ph.D.	Department Chairman
Esther D. Callard, Ph.D.	Principal Investigator and Design and Evaluation Consultant
Paul Giblin, Ph.D.	Design and Evaluation Consultant
Melissa Kaplan, Ph.D.	Design and Evaluation Consultant
Kathryn Urberg, Ph.D.	Design and Evaluation Consultant

Project Staff

Patricia E. Morin, M.A.	Project Director
Rosemarie Relich, M.A.	Associate Project Director
Susan L. Pearson	Casework Supervisor
Barbara Sugerman	Workshop Coordinator
Roberta Tillen Brown	Assistant Workshop Coordinator
Ceola O'Brien	Assistant Workshop Coordinator
Marie A. Strang, M.S.	Assistant Workshop Coordinator and Mental Health Consultant
Willie Council, Jr.	PACT Counselor
Debra Kade	"
Callie Kendrick	"
Beatriz M. Lande	"
Suzanne C. Meagher	"
Doris Miller	"
Douglas H. Monthei	"
Rosaana Pardo	"
Nancy F. Sapala	"
Colleen Spurgis	"
Charles L. Johnson	Transportation Manager
Matthew Vaive	Transportation Manager
Harriet Bernstein	Office Manager
Amber Fuller	"
Abigail C. Hafner	"
Patricia Canady	Student Assistant
Mara S. Katz	"
Janice LaLonde	"
Susan Marijanovich	"
Nadia Sawka	"
Darlena Whiten	"
Dorothy A. Bragg	Surrogate Parent
Joe Kaczor	Surrogate Sibling
Elizabeth Shackleton	"
James Stanley	"
Thomas Stanley	"
Elizabeth A. Stine	"
Bertha Thomas	"

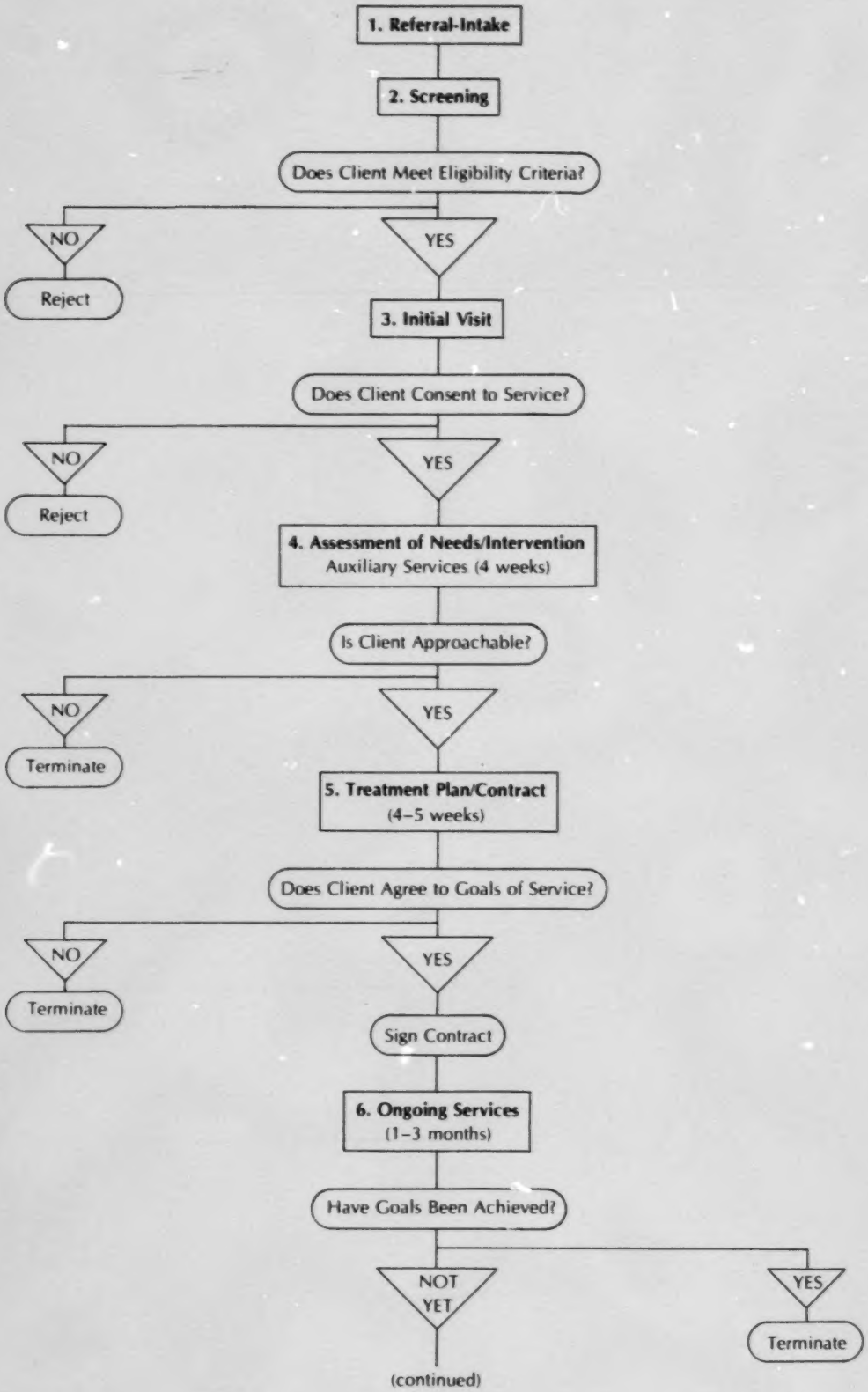
(continued on next page)

APPENDIX A (continued)

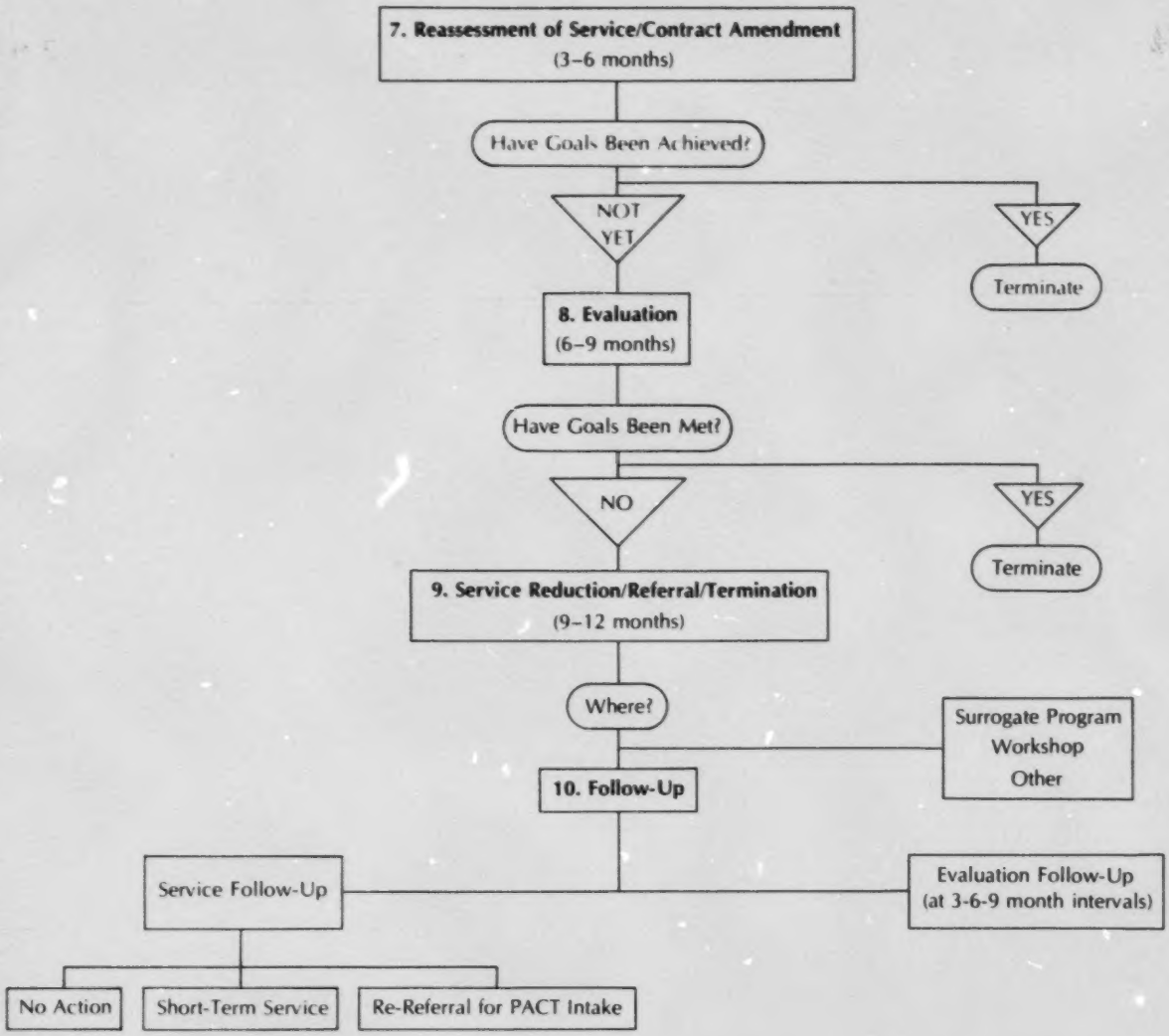
Consultants

Phyllis A. Ashinger, M.A.	Department of Family & Consumer Resources
Susan Ankrom	Hotline, Inc.
Robert O. Bland, Ph.D.	Merrill-Palmer Institute
Mary Jane Bostick, M.Ed.	Department of Family & Consumer Resources
Linda Bush, M.S.W.	Wayne County Department of Social Services
Ann Byrnes, M.D., R.D.	DMIC - PRESCAD
Lila Cabbil, M.A.	Greater Detroit Society for the Blind
Elizabeth Cathcart, M.S.W.	Detroit Board of Education
Virginia Cockett, R.N., P.H.N.	City of Detroit Health Department
Kim Dietrich, M.A.	Department of Psychology, Wayne State University
Donald N. Duquette, J.D.	Law Study Clinic, University of Michigan
Joseph Findling, L.L.B., M.S.W.	Wayne County Juvenile Court
Marilyn Gentile, M.S.W.	Psychotherapist
Selma Goode	West Side Mothers
Robert Jandrusina, M.A.	Wayne County Department of Social Services
Tommie Mae Evans Lee, M.Ed.	College of Education, Wayne State University
Anne Linn, M.A.	Department of Family & Consumer Resources
Sharon Meltzer, M.A.	Child Abuse and Neglect Center, Children's Hospital
Ernestine Moore, M.S.W.	Wayne County Department of Social Services
Richard Parres, Ph.D.	College of Education, Wayne State University
Ralph Patterson, M.S.W.	Wayne County Department of Social Services
Jean Porter, M.S.W.	Wayne County Department of Social Services
Norman Nigro, L.L.B.	Attorney
Nicholas C. Relich, M.D.	St. John Hospital, Pediatric Outpatient Services
Rochelle L. Robbins, Ph.D.	Department of Psychology, Wayne State University
Marian I. Reavey, M.S.W.	School of Social Work, Wayne State University
Jane F. Ronan, B.S.N., M.A.	College of Nursing, Wayne State University
Leora Shelef, Sc.D.	Department of Family and Consumer Resources
Nathan Shier, Ph.D.	Department of Family and Consumer Resources
Karen Schroeder, P.H.N., R.N.	Children's Center of Wayne County
Emma Shiefman, M.A.	Department of Family and Consumer Resources
Pamela Skubick, M.S.W.	Detroit Central City Community Mental Health
Agnes Smith, R.N., P.H.N.	City of Detroit Health Department
Sally Stinson, M.A.	Merrill-Palmer Institute
Donna Strong	Foster Parent, Lutheran Social Services of Michigan
Karen Szymanski, M.A.	Department of Family and Consumer Resources
Dorothy M. Thomas, M.Ed.	Detroit Public Schools, Project FIND
George Waters, M.A.	Wayne County Intermediate School District
Betty Weymouth, M.S.W.	Wayne County Intermediate School District
James G. Wilson, J.D.	Law Study Clinic, University of Michigan
Rosemarie Rymarz, R.N., B.S.	Health Care Institute, Wayne State University

APPENDIX B: PACT Program Flow Chart of Services



APPENDIX B (continued)



APPENDIX C: PACT Referral

Code No. _____ Date _____

Team _____ By _____

Name of Agency _____

Address _____ City _____ Zip _____

Telephone Number _____ Contact Person _____

Family Surname _____ (Race: _____ Marital Status: _____)

Father _____ D.O.B. _____ Mother _____ D.O.B. _____

Children _____ D.O.B. _____ / _____ D.O.B. _____

_____ D.O.B. _____ / _____ D.O.B. _____

_____ D.O.B. _____ / _____ D.O.B. _____

_____ D.O.B. _____ / _____ D.O.B. _____

_____ D.O.B. _____ / _____ D.O.B. _____

Address _____ City _____ Zip _____

Telephone _____

Other Relatives in Home _____

D.S.S. Case # _____ Name of PS/FC Worker _____ Phone _____

Reason for Referral (Removed from home, include name and whereabouts) _____

_____ Length of time in FC _____

Reason for Referral (At risk of being placed and why) _____

_____

Does family meet eligibility criteria? (Specify if not applicable)	YES	NO	UNKNOWN
1. Target child(ren) at risk of being placed.	___	___	_____
2. Target child(ren) to return home from placement in one to three months.	___	___	_____
3. Family is in current caseload of WCDSS Foster Care or Protective Services (does not have to be receiving aid payments) Specify active_____ or closed_____.	___	___	_____
4. Parent(s) is/are not alcoholics or is/are successfully rehabilitating.	___	___	_____
5. Parent(s) is/are not drug addicts or is/are successfully rehabilitating.	___	___	_____
6. There is no violent male or female in the home.	___	___	_____

APPENDIX C (continued)

	YES	NO	UNKNOWN
7. Parent(s) want child(ren) back.	___	___	_____
8. Parent(s) do not want child(ren) placed out of the home.	___	___	_____
9. Family has no history of severe abuse of a sadistic nature.	___	___	_____
10. Parent(s) have no psychosis of a chronic nature.	___	___	_____
11. Parent(s) are not severely retarded.	___	___	_____

FAMILY SITUATION

REPORTED NEEDS OF FAMILY

THREE GOALS REFERRING AGENCY WOULD LIKE PACT TO PURSUE

1.

2.

3.

ADDITIONAL COMMENTS

Source of Income:

Next Court Hearing:

111

APPENDIX D: Review of Social Services Record

Date Referred_____ Team Assigned_____
Date Reviewed_____ Date Assigned_____

FAMILY SURNAME:_____ PS/FC Worker_____
PACT Code #:_____ Telephone_____
DSS Case #_____

MARITAL STATUS:_____

RACE:_____ RELIGION_____ ETHNIC ORIGIN_____

FAMILY INFORMATION (In this order: parents, siblings, other relatives, friends)

Relationship	Name	Address (incl. zip)	Phone	D.O.B.	Soc. Sec.

TARGET CHILDREN

Name	Foster Care	Home	Name	Foster Care	Home

APPENDIX D (continued)

LEGAL STATUS: Temporary Court Ward_____ Voluntary_____ In Foster Care_____
Permanent Court Ward_____ Involuntary_____ In Custody of Parents_____

Number of Placements_____ Dates of Placements_____

Visitation (Indicate specific visitation arrangements and/or restrictions and reasons)

PREVIOUS AGENCY INVOLVEMENT (Date, Name of Agency, Address, Telephone, Contact Person, Type of Contact)

REASON FOR D.S.S. INVOLVEMENT (State Problem)

APPENDIX D (continued)

FINANCIAL STATUS (Indicate source of income, amount, I.D. number, branch office; if employed, indicate where)

HOME SITUATION (Include number of persons living in home, description of physical environment, etc.)

PHYSICAL AND MENTAL HEALTH (History of each member; strengths/weaknesses; note if problems occurred before or after placement; identify handicaps and/or special needs of child)

Current Doctor or Clinic (name, address, phone)

Is any family member on medication? yes_____ no_____ If yes, identify type and instructions

SOCIAL HISTORY (Identify relationship with children, with parents, and significant others and significant behaviors)

DEVELOPMENTAL INFORMATION

APPENDIX D (continued)

EDUCATION (Include level of education of parents and children, schools attended, location, any problems, etc.; if available, include current grade level, remarks about performance, adjustment, areas of need for special help)

OTHER

SERVICE NEEDS (Include court action pending, etc., and problems which reportedly lead, will lead, or led to placement)

ASSESSMENT OF RISKS (Include notable attitudes toward child/parent, his/her return, special problems, DSS/Agency/Court recommendations for return)

SERVICE PLAN - D.S.S./Referral Agency/PACT

1. Short-range goals

   A. Parents

      1.

      2.

      3.

   B. Target Children

      1.

      2.

      3.

ASSESSMENT OF RISKS (Include notable attitudes toward child/parent, his/her return, special problems, DSS/Agency/Court recommendations for return)

SERVICE PLAN - D.S.S./Referral Agency/PACT

1. Short-range goals

   A. Parents

      1.

      2.

      3.

   B. Target Children

      1.

      2.

      3.

APPENDIX D (continued)

2. Long-range goals

   A. Parents

      1.

      2.

      3.

   B. Target Children

      1.

      2.

      3.

APPENDIX E: Consent Form to PACT Project

Parents and Children Together is a program offered to you through the Wayne County Department of Social Services. Our program is designed to help you handle different kinds of problems you may be having at home such as management type problems or problems with your children. The overall goal of our program is to promote the welfare of you and your family. The service is extended to you in order to help you as much as possible in keeping your family together.

If you agree to join our program:

1) Your PACT counselor will visit you as often as 2-3 times a week for three to six months. Your counselor will advise and help you with any problems you may be having.

2) A few weeks after service begins and near the end of our service to you, your child (or children) will be observed to see how they are developing. These observations will be at your home and at our Center on Wayne State University's campus.

3) During the same visit to our Center, you will be asked questions about your work at home, your expectations of your child's (or children's) development and progress and questions about how you feel about yourself and your family.

In addition:

1) Your participation in this program is completely voluntary. You are free to withdraw your consent and discontinue your involvement at any time.

2) Your decision to join or not join will in no way affect the services you may be receiving from the Department of Social Services.

3) All information is confidential and your identity will not be revealed.

We must make it clear to you that we are going to do everything possible to help you solve any management problems you might be having. But at the same time, we expect your cooperation in solving these problems. Although our main purpose is to help you work things out, if we find there is little or no progress being made after a limited period of time, then we will confer with the Department of Social Services and recommend other steps that may be taken in the best interest of you and your child (or children). Your continuing progress with the PACT counselors will be reported to the Wayne County Department of Social Services and other related agencies.

On the basis of the above statement, do you agree to participate in the program?

Yes_____

No_____ Date_____

Project Director_____ Date_____

APPENDIX F: Needs Assessment

Current Status and Assessment of Family by Area of Service

A. Financial (Income/Expenses)

1. indicate source and amount of income, employer, and occupation, if any
2. assess expenses of family
3. assess whether income is sufficient to ensure a minimum level of economic security and necessities such as:
   a. food in sufficient quantity and quality for nutrition
   b. clothing that is becoming, clean, and kept in repair, and that does not humiliate or set the family apart from others
   c. housing that accommodates the family members
   d. incidentals for personal grooming, newspapers, school activities, occasional recreation, telephone, television, etc.
4. indicate whether caregiver(s) appear knowledgeable and skillful in low-income budgeting

B. Environment

Assess whether environment is adequate. Is family located in a safe neighborhood, in housing that is safe, clean, comfortably furnished, with light, heat, water, and sanitary facilities?

1. describe external environment
   a. neighborhood
   b. type of housing
   c. condition of housing
2. describe internal environment
   a. size, number of rooms
   b. facilities, i.e. lights, heat, water, plumbing, appliances
   c. furnishings
   d. organization, orderliness, cleanliness
3. indicate family's ability to organize and maintain a safe and healthy home environment

C. Developmental Status

Indicate current development and functioning of each family member, if known. Use the adult and child screening forms in addition to the following.

1. appearance--description of parents/children in terms of height, weight, race, sex, and any distinguishing features; appropriateness of dress, grooming
2. language
   a. use of language, i.e. conversation, quantity of speech - is language comprehensible
   b. understanding of spoken language
   c. note any distinguishing features
3. social
   a. age and role-appropriate behavior in relation to parents, siblings, other family members, school, peer groups, neighborhood, job.
   b. the degree and manner to which social needs of family members are satisfied, i.e. recreation, support systems, friendships
4. emotional
   a. the degree and manner to which emotional needs of family members are expressed and satisfied, i.e. anger, fear, joy, positive and negative

C. Developmental Status (continued)

4. emotional (continued)
   b. inappropriate displays of emotion
   c. sense of self-worth/esteem
5. physical
   a. gross and fine motor development for children under 6 years
   b. note any distinguishing features for family members over 6 years
6. educational/vocational
   a. include level of education of parents and children, school attendance, problems/strengths (if available, include remarks about performance, adjustment, areas requiring special help)
   b. include adequacy of vocational opportunities for developing special interests, talents, and learning how to earn a living

Indicate caregiver(s) ability to improve and/or maintain development and functioning of each family member.

D. Quality of Caregiver(s)-Child(ren) Interaction

1. understanding and sensitivity to child's cues, i.e. crying, illness, verbalizations, bids for attention, fatigue
2. parental attitudes
   a. parents' manifest feelings toward children
      1) negative feelings--rejection, anger, depression, withdrawal, anxiety
      2) positive feelings--warmth, pride, acceptance, supportive
3. children's attitudes toward caregiver(s)
   a. children's manifest feelings toward parents
      1) negative feelings
      2) positive feelings
4. if appropriate, describe
   a. differential treatment of children
   b. how the parent's experience with the child has been affected by his/her own childhood experience
   c. how the parent's relationship to the child is affected by environmental and family stresses, or by personality and problems of the child
5. indicate caregiver(s) ability to improve and/or maintain sensitivity and understanding of the child(ren)'s needs

E. Child Management Skills

1. ability to set realistic expectations for child(ren)
2. recognition of child's abilities and developmental skills including stimulation and encouragement of the child
3. competency in meeting routine living requirements of meals, school attendance, sleeping routines, homework times, learning and socialization experiences and keeping appointments
4. indicate how physical care, guidance, discipline and supervision are provided
   a. how each parent assumes responsibility, uses authority, and serves as a role model

F. Nutrition

1. assess nutritional adequacy of choice of foods
2. adequacy of meal preparation and food storage techniques
3. note any misconceptions about nutrition
4. indicate ability to maintain and/or improve nutritional standards

G. Current Health and Hygiene Status of Family Members

Indicate current medical status of each family member and past medical history if relevant.

1. parental medical status
   a. general health
   b. name of general medical doctor and/or specialist(s)
   c. history of difficult pregnancies, if relevant
   d. clinical diagnosis, etiology and treatment when appropriate, including any disabilities
   e. note any familial high risk tendencies, i.e. substance abuse, specific disorders
2. child(ren)'s medical status
   a. general health
   b. name of general medical doctor and/or specialist(s)
   c. medical history if relevant to current status
   d. clinical diagnosis, etiology and treatment when appropriate including any disabilities
3. conditions of environment affecting health and hygiene including availability and use of health resources
4. indicate caregiver(s) ability to maintain and/or improve health and hygiene standards and obtain treatment for illness and any disabilities

H. Mental Health

Indicate current mental health of each family member and past history if relevant.

1. parental mental health
   a. observed stress situations
   b. history of psychiatric hospitalizations and clinical diagnosis and treatment when appropriate
   c. observed psychological problems
   d. conditions of environment affecting mental health
2. child(ren)'s mental health
   a. observed stress situations
   b. history of psychiatric hospitalizations and clinical diagnosis and treatment when appropriate
   c. observed psychological problems
   d. conditions of environment affecting mental health
3. indicate caregiver(s) ability to maintain and/or improve mental health standards of family members

I. Current Involvement with Agencies

1. list name of agency, address, telephone, contact person, and type of contact. Include type of program and length of time involved in program
2. factors affecting use of community resources for the parents and children, i.e. location, proximity to transportion, income, etc.
3. indicate family's ability to maintain and/or improve utilization of community resources

J. Other Pertinent Information

Recommendations Based on Assessment

Based on the above, what is your assessment of the family's potential to benefit from PACT services. Include family's current relationship/rapport with the PACT team/core counselor.

APPENDIX G: Monthly Update Report

For Month Of _____

To: _____

Address _____ City _____ Zip _____

Client Name _____

Address _____ City _____ Zip _____ Phone _____

Target Child(ren) _____ _____

_____ _____

_____ _____

_____ _____

1. Date Service Initiated _____

2. Home Visits on Following Dates _____

_____

3. Goals of Service

a. _____

b. _____

c. _____

d. _____

e. _____

4. What Happened During Month (Briefly note what team did, client's responses, attitudes, attempts to handle problems, etc. If necessary, include detailed description of significant events.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

APPENDIX G (continued)

5. New Developments (Note progress on children, additional information or insights obtained since last recording, other information to maintain current knowledge, new service needs, etc.)

6. Service Plan (Next steps, continuation or changes in plan or method, referrals to be made, reasons for changes and referrals, if client is terminated, state recommended long-term goal and reasons for recommendation.

TEAM _____

DATE _____

APPENDIX H: PACT Admission Form

FAMILY I.D._____ DATE OF ADMISSION_____

BIRTHDATE OF MOTHER _____ HIGHEST GRADE COMPLETED _____

RELIGION _____
1. Protestant
2. Catholic
3. Jewish
4. Moslem
5. Other _____
6. None

RACE _____
1. Caucasian
2. Negro
3. American Indian
4. Asiatic
5. Hispanic
6. Other _____

MARITAL STATUS _____
1. Married
2. Widowed
3. Separated
4. Divorced
5. Never Married

REFERRAL SOURCE _____
1. DSS-PS
2. DSS-FC
3. Social Agency
4. Court System
5. MH Program/Hospital
6. PH Program/Hospital
7. Private Physician
8. School
9. Family friend
10. Self
11. Public Health Nurse
12. Church
13. Other _____

RESIDENCE _____
1. Public Housing
2. House
3. Private Apt.
4. Rooming House
5. Hotel
6. Halfway House/Residential
7. Itinerant
8. Incarcerated
9. Hospital
10. Other _____

CLIENT IS_____
1. Owner
2. Tenant
3. Contributes
4. Non-Paying

NO. OF ROOMS OCCUPIED ___

PERSONS LIVING WITH CLIENT - Indicate the number of relatives and friends living in the same shelter unit as the client.

Daughter _____ Son _____ Mother _____ Father _____ Sister _____ Brother _____

Other Relatives _____ Cohabitant _____ Unrelated male adults _____ Unrelated female adults_____

Unrelated children _____

CLIENT'S COHABITATION _____
1. None
2. Legal Spouse
3. Other Person - Opposite Sex
4. Other Person - Same Sex

EMPLOYMENT STATUS _____
1. Full time
2. Part time
3. Unemployed

SOURCE OF SUPPORT _____
1. Salary/Wages
2. Welfare Benefits
3. Social Security
4. Other Pension
5. Unemployment Insurance
6. Illegal Activities
7. Dependent on Others
8. None
9. Other _____

FAMILY'S ANNUAL INCOME _____

APPENDIX H (continued)

CLIENT'S PROGENY - Indicate total number of children _____

Number 0-5 years____ 6-12 years____ 13-15 years____ 16-18 years____ 19+ years____

LEGAL STATUS OF CHILDREN:

NAME	AGE	CLIENT'S CUSTODY	COURT WARDS	GUARDIAN-SHIP	HOSPITAL	EMER. SHELTER	INDEPENDENT

APPENDIX H (continued)

HISTORY OF FOSTER CARE PLACEMENTS:

NAME	AGE	PLACEMENT DATES	LOCATION OF PL. (home, group)	V-I	REASON FOR PLACEMENT*

*REASONS FOR PLACEMENT

1. Physical, sexual, psychological abuse
2. Physical, emotional, medical neglect
3. Alcoholism in parent
4. Drug addiction in parent
5. Parental abandonment
6. Parent hospitalized
7. Mental illness in parent
8. Mental retardation in parent
9. Antisocial behavior in parent
10. Antisocial behavior in child
11. Child emotionally disturbed
12. Child mentally retarded
13. Conjugal discord
14. Inadequate housing
15. Other

APPENDIX H (continued)

FAMILY HISTORY - [1] Indicate the presence of problems in each parent's background.

	PSYCHIATRIC PROBLEMS	DRUG ABUSE	ALCOHOL ABUSE	CRIMINAL ACTIVITY	IMPRISONMENT
MOTHER					
FATHER					

- [2] Indicate history of any foster care placements of the parents.

MOTHER

AGE AT PLACEMENT	DATES OF PLACEMENT	LOCATION OF PLACEMENT (home, group)	VOLUNTARY/ INVOLUNTARY	REASONS FOR PLACEMENT

FATHER

AGE AT PLACEMENT	DATES OF PLACEMENT	LOCATION OF PLACEMENT (home, group)	VOLUNTARY/ INVOLUNTARY	REASONS FOR PLACEMENT

APPENDIX I: Inventory of Home Stimulation

Child's Name_____ Code #_____ Date_____

Interviewer_____

Subscore ___ ___ ___ ___ ___ ___ Total_____
1 2 3 4 5 6

I. EMOTIONAL AND VERBAL RESPONSIVITY OF MOTHER

1. True___ False ___ Mother spontaneously vocalizes to child at least twice during visit (exclude scolding).
2. True___ False ___ Mother responds to child's vocalizations with a vocal or verbal response.
3. True___ False ___ Mother responds to child's vocalizations with a positive non-verbal response (e.g., smile, hug, nod, eye-contact, etc.).
4. True___ False ___ Mother tells child the name of some object during visit or says name of person or object in a "teaching" style.
5. True___ False ___ Mother positively reinforces child for age appropriate verbal behavior.
6. True___ False ___ Mother's speech is distinct, clear, and audible to interviewer.
7. True___ False ___ Mother initiates verbal interchanges with observed--asks questions, makes spontaneous comments.
8. True___ False ___ Mother expresses ideas freely and easily and uses statements appropriate length for conversation (e.g., more than brief).
9. True___ False ___ Mother spontaneously praises child's qualities or behavior twice during visit.
10. True___ False ___ Mother shows some positive emotional responses to praise of child offered by visitor.

SUBSCORE _____

II. AVOIDANCE OF RESTRICTION AND PUNISHMENT

11. True___ False ___ Mother does not shout at child during visit.
12. True___ False ___ Mother does not shout at child other than for dangerous or destructive behaviors.
13. True___ False ___ Mother does not express overt annoyance or hostility toward child.
14. True___ False ___ During visit, mother does not threaten punishment without follow-up.
15. True___ False ___ Mother neither slaps nor spanks child during visit.
16. True___ False ___ Punishment is given immediately after occurrence of inappropriate behavior.
17. True___ False ___ Child does not show apprehension, fear or defensiveness upon approach of mother (doesn't try to protect self).
18. True___ False ___ Mother does not scold nor derogate child during visit.

APPENDIX I (continued)

19. True____ False ____ Child is not left in isolation as punishment longer than 1/2 hour per day.

20. True____ False ____ Child is/was not whipped or spanked for having an "accident" (wetting pants or bed).

SUBSCORE_____

III. ORGANIZATION OF PHYSICAL AND TEMPORAL ENVIRONMENT

21. True____ False ____ Child is never left without an adult (or child over 12) actually being present.

22. True____ False ____ Child gets out of house at least four times a week.

23** True____ False ____ Child taken regularly to doctor's office or clinic for check-ups and preventive health care.

24** True____ False ____ Child has a special place in which to keep his toys and "treasures".

25. True____ False ____ Child's home environment appears safe and free of hazards.

26. True____ False ____ Child's meals are eaten with one or more adults present at a table on most days.

27. True____ False ____ Is mealtime a pleasant and relaxed period of the day?

28a. True____ False ____ (For age 0 through 12 months) Child is cuddled and held during feeding time with breast or bottle.

28b. True____ False ____ (For age 1 through 12) What are meals like? Does child enjoy this time?

29. True____ False ____ Child's bedtime and nap conform to a predictable regular schedule most days.

30. True____ False ____ Housekeeping standards indicate that children are present (i.e., do not appear excessively rigid).

31. True____ False ____ Housekeeping standards do not appear excessively chaotic or dirty.

32. True____ False ____ Are most TV viewing decisions made by the child?

SUBSCORE_____

IV. PROVISION OF APPROPRIATE PLAY MATERIALS

33. True____ False ____ Child has toys for large muscle activity (e.g., sports equipment, balls, bats, jump rope, boxing gloves).

34* True____ False ____ Child has wheeled vehicle (e.g., scooter, bike).

35. True____ False ____ Parent provides toys appropriate to age.

36* True____ False ____ Parent provides eye-hand coordination toys (e.g. birth to 3 years: stack and nesting toys, blocks, pop beads; 4 to 12 years: lego, Lincoln logs, puzzles).

*May require an interview probe unless this can be observed.
**Will require an interview probe unless mother mentions spontaneously.

APPENDIX I (continued)

37. True____ False ____ Parent provides books appropriate to age.

38. True____ False ____ Child is not permitted to play with dangerous objects (such as knives, glass, electrical cords, etc.).

39. True____ False ____ (For ages 5 through 12 only) Table games, board games or other group games are provided child (e.g., cards, marbles, checkers).

SUBSCORE_____

V. MATERNAL INVOLVEMENT WITH CHILD

40* True____ False ____ Mother consciously encourages developmental advance.

41. True____ False ____ Mother engages in some play activity with child at least once a day.

SUBSCORE_____

VI. OPPORTUNITIES FOR VARIETY IN DAILY STIMULATION

43** True____ False ____ Mother reads to or looks at books with child at least once a week.

44** True____ False ____ Family visits or receives visits from relatives approximately once a month? (How often?_____).

45** True____ False ____ Family visits or receives visits from adult friends approximately once a month? (How often?_____).

46** True____ False ____ Does child visit or receive visits from his/her peers? How often?_____).

SUBSCORE_____

APPENDIX J: Child Social Adjustment Scale

Parent's Name_____ Child's Name_____ Code_____ Date_____

Some of these questions may be difficult for you to answer. We would like you to note how certain you are of your answer. There are three categories:

1. Certain: seen by yourself or reported to you by at least two independent sources (e.g., child, mother, other adult).
2. Somewhat certain: not seen by you but reported by one other person who you have no reason to doubt.
3. Uncertain: questionable or conflicting information.

Peer Relations (not siblings)

Certainty Factor		Never	Rarely	Sometimes	Often
_____	1. Has friends None 1-2 3-5 More				
_____	2. Physically aggressive toward peers	_____	_____	_____	_____
_____	3. Friends get into trouble	_____	_____	_____	_____
_____	4. Voluntarily spends at least 1 hour a day with peers	_____	_____	_____	_____
_____	5. Nurturant/sensitive to other children	_____	_____	_____	_____

Family Relations

_____	1. Displays affection toward parent	_____	_____	_____	_____
_____	2. Demands too much attention	_____	_____	_____	_____
_____	3. Asks for help when needed (makes instrumental use of adults)	_____	_____	_____	_____
_____	4. Responsive to parents' requests	_____	_____	_____	_____
_____	5. Conversation with parents often and lively	_____	_____	_____	_____

Emotional Development

_____	1. Angry, hostile	_____	_____	_____	_____
_____	2. Depressed, sad	_____	_____	_____	_____
_____	3. Happy, pleased, content	_____	_____	_____	_____
_____	4. Rapid shift in mood	_____	_____	_____	_____
_____	5. Cries with little provocation	_____	_____	_____	_____
_____	6. Unreasonable displays of anger/ temper tantrums	_____	_____	_____	_____
_____	7. Shows pride in self or accomplishments	_____	_____	_____	_____
_____	8. Monitors and controls own behavior appropriately	_____	_____	_____	_____
_____	9. To what extent does child control own behavior	_____	_____	_____	_____

APPENDIX J (continued)

Family Name_____ Code_____ Date_____

Emotional Development (continued)

Certainty Factor		Never	Rarely	Sometimes	Often
_____	10. Aggressive toward environment	_____	_____	_____	_____
_____	11. Attempts to manipulate adults	_____	_____	_____	_____

Relationships with Teachers and Other Adults (not family)

_____	1. School behavior problems	_____	_____	_____	_____
_____	2. Open and responsive to adults	_____	_____	_____	_____
_____	3. Defiant and rude to adults	_____	_____	_____	_____
_____	4. Aware and responsive to social expectations	_____	_____	_____	_____

Problems		Yes	No
_____	1. Drugs or alcohol	_____	_____
_____	2. Runs away	_____	_____
_____	3. Lies	_____	_____
_____	4. Steals	_____	_____
_____	5. Sets fires	_____	_____
_____	6. Fully toilet trained	_____	_____
_____	7. Injures self	_____	_____
_____	8. Destroys property	_____	_____
_____	9. Injures others	_____	_____
_____	10. Tics	_____	_____
_____	11. Stutters	_____	_____
_____	12. Often confused or dazed	_____	_____
_____	13. Age and grade match	_____	_____

APPENDIX K: Initial Visit Form

Family I.D. _____

Rating of Severity

Very severe = 5 Slightly Severe = 2

Severe = 4 Minor Severity = 1

Moderately Severe = 3

Problems	Who has problem	Rating of Severity	Date problem observed
Parenting Problem Areas			
1. Inadequate supervision of children			
2. Negative disciplinary control of children			
3. Lack of positive interaction between parent and child			
4. Lack of stimulation			
5. Lack of affection			
6. Lack of attachment			
7. Inadequate knowledge of children's needs and age-appropriate behaviors			
8. Psychological abuse			
9. Physical abuse			
10. Sexual abuse			
11. Other _____			
Lack of Parental Independence			
1. Overly dependent on relative in home			
2. Unmotivated for change			
3. Overly dependent on one or more offspring			
4. Needs exceptional emotional support			
5. Illiterate			
6. Adolescent parent			
7. Immature			
8. Lack of social contacts; socially isolated			
9. Other _____			
Developmental Problems in Children			
1. Understimulation			
2. Early physical illness			

DAY CARE SERVICES

APPENDIX K (continued)

Problems	Who has problem	Rating of Severity	Date problem observed
3. Birth anomaly			
4. Congenital disease			
5. Physical abuse			
6. Psychological abuse			
7. Sexual abuse			
8. Malnutrition			
9. Lack of self-esteem			
10. Lack of mastery of age-related skills			
11. Language difficulties			
12. Learning disability			
13. Overweight			
14. Underweight			
15. Lack of exercise			
16. Failure to thrive (present)			
17. Failure to thrive (past)			
18. Overly dependent on parent or guardian			
19. Emotionally immature			
20. Mentally retarded			
21. Other _____ _____ _____ _____			
Environmental Problem Areas			
1. Living quarters in unsafe neighborhood			
2. " " beyond repair			
3. " " pest infested			
4. " " unsanitary			
5. " " unclean			
6. " " underfurnished			
7. " " messy			
8. Inadequate plumbing			
9. Inadequate laundry facilities			
10. Inadequate sleeping quarters			
11. Inadequate play space			
12. Inadequate stimulation			
13. Eviction imminent			
14. Living quarters lack heat and/or electricity			
15. Other _____			

APPENDIX K (continued)

HEALTH-RELATED SERVICES

Problems	Who has problem	Rating of Severity	Date problem observed
Health-Related Problem Areas			
Health Care			
1. Clinic appointments not made			
2. Clinic appointments not kept			
3. Lack of appropriate judgment about health problem			
4. Lack of follow through			
5. Children's immunizations not up to date			
6. Free health care inaccessible			
7. Lack of family planning; inadequate contraceptive methods			
8. Lack of adequate hygiene			
9. Lack of clean clothing			
10. Other _____ _____ _____ _____			
Physical Health Ailments			
Parent			
1. Nervousness			
2. Headaches			
3. Hemorrhaging			
4. Seizures			
5. Diagnosed epilepsy			
6. High blood pressure			
7. Pneumonia			
8. Uterine infection			
9. Pregnancy; problems			
10. Other _____ _____ _____ _____			
Children			
1. Fungus			
2. Rash			
3. Asthma			
4. Pulmonary lung dysplasia			

APPENDIX K (continued)

Problems	Who has problem	Rating of Severity	Date problem observed
5. Neurological dysfunction			
6. Bowed legs			
7. Failure to thrive (OMIT)			
8. Hepatitis			
9. Cleft palate			
10. Hemophilia			
11. Ear; hearing problems			
12. Eye; sight problems			
13. Dental problems			
14. Pregnancy; problems			
15. Lead poisoning			
16. Other _____ _____ _____ _____			
Mental Health Ailments			
Parent			
1. Neurotic/Psychotic illness			
2. Mental retardation			
3. Alcoholism			
4. Drug addiction			
5. Other _____ _____ _____ _____			
Financial Problem Areas			
1. Inadequate source of income			
2. Illegal source of income			
3. Not using; ignorant of supplementary source of income			
4. Spendthrift buying practices			
5. Indebtedness to creditors			
6. Uses up money too rapidly; lack of budgeting			
7. Non-payment of bills			
8. Not able to secure employment			
9. Not willing to secure employment			
10. Other _____ _____			

MONEY MANAGEMENT SERVICES

APPENDIX K (continued)

INFORMATION/REFERRAL SERS.

INVESTIGATION/INTERVENTION SERVICES

Problems	Who has problem	Rating of Severity	Date problem observed
Community Resources Problem Areas			
1. Transportation unavailable			
2. Transportation inaccessible			
3. Inconsistent use of community resources			
4. Ignorance of availability of community resources			
5. Other _____			
Social Services Problem Areas			
1. Undue difficulty in obtaining ADC			
2. " " " " SSI			
3. " " " " GA			
4. " " " " Food Stamps			
5. " " " " Medicaid			
6. " " " " Furniture			
7. " " " " Linen Order			
8. " " " " Appliances			
9. " " " " Day Care Services			
10. " " " " Homemaker Services			
11. Personality conflicts with PS/FC/ADC Worker			
12. Other _____			
School-Related Problem Areas			
1. Truancy			
2. Aggression towards peers			
3. Inappropriate placement			
4. Six or older, but not yet in school			
5. Lack of communication between parent and school			
6. Not at appropriate grade level			
7. Behind in specific subjects			
8. Other _____			

APPENDIX K (continued)

Problems	Who has problem	Rating of Severity	Date problem observed
Conjugal Discord			
1. Mate beating			
2. Continual arguments			
3. Substance abuse by mate			
4. Mate spends ADC/SSI/GA check			
5. Other _____			
Delinquency			
1. Breaking and entering			
2. Larceny			
3. Arson			
4. Rape			
5. Assault			
6. Armed robbery			
7. Run away			
8. Other _____			
Foster Care Problem Areas			
1. Inconsistent in visiting children in foster care			
2. Disinterested in visiting children in foster care			
3. Unable to visit due to lack of transportation			
4. Unable to visit due to poor health			
5. Unable to visit due to lack of communication between agency and family			
6. Barred from visitation by court order			
7. Other _____			

ADJUNCT SERVICES

APPENDIX K (continued)

IS THE TARGET CHILD OF THIS FAMILY PRESENTLY IN THE HOME? _____ YES _____ NO

If yes, please check the following that apply to the appearance and behavior of the target child and rate the severity of the characteristic:

APPEARANCE	RATING OF SEVERITY
Child has multiple cuts, bruises, burns, abrasions	
Child wears clothing inappropriate for time of year	
Child's clothing, hair and/or body is/are smelly/filthy	
BEHAVIOR	
Child is apathetic, lethargic, unresponsive	
Child displays excessive, compulsive activity (overactive and out of bounds)	
Child is excessively fearful	
Child is hostile, irritable, angry	
Child is deficient in use of language for communication	
Child displays inappropriate emotional responses	

APPENDIX L: Family Strengths

Rating Scale of Level of Strengths

1 = adequate	3 = very good
2 = good	4 = excellent

Parenting Strengths

1. Adequate supervision of children _____
2. Children well disciplined _____
3. Positive interaction between parent and child _____
4. Adequate physical, psychological stimulation of children _____
5. Affectionate with children _____
6. Definite attachment to children _____
7. Adequate knowledge of children's needs and age-appropriate behaviors _____
8. Concerned about children's well being, development, etc. _____
9. Other _____ _____
   _____
   _____
   _____

Parental Independence/Social Contacts Strengths

1. Independent decision-making _____
2. Motivated for change _____
3. Emotionally, psychologically mature _____
4. Presence of support system - available relatives/friends _____
5. Other _____ _____
   _____
   _____
   _____

Developmental Strengths of Children

1. Developmentally sound _____
2. Emotionally sound _____
3. Intellectually sound _____
4. Nutritionally sound _____
5. Absence of early physical illness _____
6. Adequate mastery of age-related skills _____
7. Normal language development _____
8. Absence of learning disabilities _____
9. Socially mature for age _____
10. Good physical tonus and shape _____
11. Other _____ _____
    _____
    _____
    _____

Environmental Strengths

1. Adequate living quarters _____
2. Good housekeeping techniques _____
3. Adequate stimulation from physical environs _____
4. Other _____ _____
   _____
   _____

APPENDIX L (continued)

Health-Related Strengths

Health Care

1. Consistent about health care _____
2. Makes appropriate judgments about health problems _____
3. Adequate family planning; use of contraception _____
4. Adequate hygiene _____
5. Presence of clean clothing _____
6. Use and accessibility of free health care _____
7. Other _____ _____

_____

_____

_____

Physical Health of Parent

1. Good health status _____
2. Energetic _____
3. Other _____ _____

_____

_____

_____

Mental Health of Parent

1. Psychologically sound _____
2. Normal intellectual functioning _____
3. Absence of substance abuse _____
4. Other _____ _____

_____

_____

_____

Nutritional Strengths

1. Organized meal times _____
2. Adequate food supply _____
3. Nutritious meal preparation _____
4. Other _____ _____

_____

_____

_____

Financial Strengths

1. Has income (ADC, job, other) _____
2. Has supplementary income (LTP, SSI, etc.) _____
3. Economical buying practices _____
4. Adequate budgeting of money _____
5. Able and willing to secure employment _____
6. Other _____ _____

_____

_____

_____

APPENDIX L (continued)

Community Resource Strengths

1. Has transportation (car) _____
2. Use and accessibility of transportation (bus, cab, etc.) _____
3. Consistent use of community resources _____
4. Other _____ _____
   _____
   _____
   _____

Social Service Strengths

1. Able to secure independently (ADC, etc.) _____
2. Knows ins and outs of social service system _____
3. Other _____ _____
   _____
   _____
   _____

School-Related Strengths

1. Children attend school regularly _____
2. Gets along well with peers _____
3. Age-appropriate grade level _____
4. Intellectually-appropriate placement _____
5. Good communication between parent and school _____
6. Does well in studies _____
7. Other _____ _____
   _____
   _____
   _____

Conjugal Strengths

1. Lives harmoniously with mate _____
2. Mate contributes to household support _____
3. Other _____ _____
   _____
   _____
   _____

Foster Care Strengths

1. Regularly visits children in foster care _____
2. Wants children to remain in the home _____
3. Wants children to return home _____
4. Other _____ _____
   _____
   _____
   _____

APPENDIX M: Daily Activity Record

DIRECTIONS: Immediately complete after every visit to the family.

_____
Family Identification No.

_____
Date

_____
_____
_____
_____
_____
Family Members Present

_____
_____
_____
_____
_____

_____
Name of Workers

Location of Visit _____

01. Telephone call
02. Family's home
03. Hospital; clinic
04. School
05. Social Service Agency
06. Donation agency
07. Store
08. PACT office
09. Restaurant
10. Other _____

Was visit: Scheduled _____
Drop in _____

Duration of visit: _____
(Indicate in time units)

Problem Areas Discussed (Refer to Initial Visit Problem List for specifications of problems)

01. Parenting Problems _____
02. Lack of Parental Independence _____
03. Developmental Problems in Children _____
04. Environmental Problems _____
05. Health Care Problems _____
06. Physical Health Ailments in Parent _____
07. Physical Health Ailments in Children _____
08. Mental Health Ailments in Parent _____

145

APPENDIX M (continued)

09. Nutrition Problems _____

10. Financial Problems _____

11. Community Resource Problems _____

12. Social Service Problems _____

13. School-Related Problems _____

14. Delinquency _____

15. Conjugal Discord _____

16. Foster Care Problems _____

Problem Solving Activities Employed
(Match Each Problem Discussed with the Appropriate Activity, using the corresponding problem code.)

01. Family discussion	___	___	___
02. Educational presentation	___	___	___
03. Talking/meeting with agency personnel	___	___	___
04. Seeking med/psy treatment	___	___	___
05. Talking/meeting with school officials	___	___	___
06. Picking up donations	___	___	___
07. House hunting	___	___	___
08. Talking/meeting with real estate agents	___	___	___
09. Shopping	___	___	___
10. PACT Workshop	___	___	___
11. PACT Interview	___	___	___
12. Other _____	___	___	___

Time Spent in Each Activity and Each Problem Area
(Specify in the parentheses provided if problem area was mainly centered on the family as a whole (F), on the target child (TC), or non-target children (NTC).

01.	___( )	___( )	___( )
02.	___( )	___( )	___( )
03.	___( )	___( )	___( )
04.	___( )	___( )	___( )
05.	___( )	___( )	___( )
06.	___( )	___( )	___( )
07.	___( )	___( )	___( )
08.	___( )	___( )	___( )
09.	___( )	___( )	___( )
10.	___( )	___( )	___( )
11.	___( )	___( )	___( )
12.	___( )	___( )	___( )

APPENDIX M (continued)

Family Response to Activity (Use the appropriate activity codes) Bonus Effects

1. Involved; interested (high individual motivation _____ _____
2. Accepting (low individual motivation) _____ _____
3. Ambivalent _____ _____
4. Not accepting; dislike _____ _____
5. Hostile; totally uninvolved _____ _____

Condition of Physical Environment (if applicable)

1. Excellent _____
2. Good _____
3. Average _____
4. Bad _____
5. Extremely Bad _____

Approaches to Problem Solving (Use the appropriate problem area codes)

1. Reeducation _____
2. Behavior Modification _____
3. Coercive persuasion; ultimatums _____
4. Modeling and demonstration _____
5. Listening _____
6. Helpful suggestions _____

APPENDIX N: Monthly Assessment

Family I.D. _____

Rating of Severity

Very severe = 5 Slightly severe = 2
Severe = 4 Minor severity = 1
Moderately severe = 3

PROBLEMS	OLD	NEW	SOLVED	RATING OF SEVERITY 1	2	3	4	5
01. Parenting Problems								
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
02. Lack of Parental Independence								
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
03. Developmental Problems in Children								
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								
16.								
17.								
18.								

APPENDIX N (continued)

Family I.D. _____

PROBLEMS	OLD	NEW	SOLVED	RATING OF SEVERITY				
				1	2	3	4	5
04. Environmental Problem Areas								
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								
05. Health Care Problems								
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
06. Physical Health Ailments in Parent								
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

APPENDIX N (continued)

Family I.D. _____

PROBLEMS	OLD	NEW	SOLVED	RATING OF SEVERITY 1	2	3	4	5
07. Physical Health Ailments in Children								
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								
16.								
08. Mental Health Ailments in Parent								
1.								
2.								
3.								
4.								
5.								
09. Nutritional Problem Areas								
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
10. Financial Problem Areas								
1.								
2.								
3.								
4.								
5.								
6.								

APPENDIX N (continued)

Family I.D. _____

PROBLEMS	OLD	NEW	SOLVED	RATING OF SEVERITY 1	2	3	4	5
7.								
8.								
9.								
10.								
11. Community Resources Problem Areas								
1.								
2.								
3.								
4.								
5.								
12. Social Services Problem Areas								
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13. School Related Problem Areas								
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								

APPENDIX N (continued)

Family I.D. _____

PROBLEMS	OLD	NEW	SOLVED	RATING OF SEVERITY 1	2	3	4	5
14. Delinquency								
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
15. Conjugal Discord								
1.								
2.								
3.								
4.								
5.								
16. Foster Care Problem Areas								
1.								
2.								
3.								
4.								
5.								
6.								
7.								

APPENDIX O: Social Service Evaluation

Family I.D. _____

Date _____

What social services procedures seem to be contributing to the solution of past, current and future problems this family may be experiencing?

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

What social services procedure seems to be contributing to the past, current and future problems this family may be experiencing?

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

APPENDIX P: PACT Termination Form

Family I.D. _____ DATE OF TERMINATION _____

EDUCATION COMPLETED DURING SERVICE _____

1. High School
2. GED courses
3. Technical school
4. College courses
5. Vocational rehabilitation
6. Other _____
7. None

EMPLOYMENT STATUS AT TERMINATION _____

1. Full time
2. Part time
3. Unemployed

SOURCE OF SUPPORT _____

1. Salary/Wages
2. Welfare Benefits
3. Social Security
4. Other Pension
5. Unempl. Benefits
6. Illegal activities
7. Dependent upon others
8. None
9. Other _____

FAMILY'S ANNUAL INCOME AT TERMINATION _____

MARITAL STATUS AT TERMINATION _____

1. Married
2. Widowed
3. Separated
4. Divorced
5. Never Married

RESIDENCE AT TERMINATION _____

1. Public housing
2. House
3. Private apt.
4. Boarding/Rooming house
5. Hotel
6. Halfway house/Residential
7. Hospital
8. Itinerant
9. Incarcerated
10. Other _____

CLIENT IS _____

1. Owner
2. Tenant
3. Contributes
4. Non-Paying

NO. OF ROOMS OCCUPIED _____

PERSONS LIVING WITH CLIENT - Indicate the number of persons living within the same shelter unit as the family.

Daughter _____ Son _____ Mother _____ Father _____ Sister _____ Brother _____

Other Relatives _____ Cohabitant _____ Unrelated male adults _____ Unrelated female adults _____

Unrelated children _____

CLIENT'S COHABITATION _____

1. None
2. Legal Spouse
3. Other Person - Opposite Sex
4. Other Person - Same Sex

APPENDIX P (continued)

CLIENT'S PROGENCY - Indicate total number of children _____

Number 0-5 years ____ 6-12 years ____ 13-15 years ____ 16-18 years ____ 19+ years ____

LEGAL STATUS OF CHILDREN AT TERMINATION:

NAME	AGE	CLIENT'S CUSTODY	COURT WARDS	GUARDIAN-SHIP	HOSPITAL	EMER. SHELTER	INDEPENDENT

FOSTER CARE PLACEMENTS AT TERMINATION:

NAME	AGE	PLACEMENT DATES	LOC. OF PL. (home, group)	VOLUNTARY/ INVOLUNTARY	REASONS FOR PLACEMENT
		(			
		(			
		(			
		(			
		(			
		(			
		(			
		(			

REASONS FOR PLACEMENT

1. Physical, sexual, psychological abuse
2. Physical, emotional, medical neglect
3. Alcoholism in parent
4. Drug addiction in parent
5. Parental abandonment
6. Parent hospitalized
7. Mental illness in parent
8. Mental retardation in parent
9. Antisocial behavior in parent
10. Antisocial behavior in child
11. Child emotionally disturbed
12. Child mentally retarded
13. Conjugal discord
14. Inadequate housing
15. Other

APPENDIX P (continued)

This part of the termination report reviews the primary goals of this project and how they have been met. Each section should include the initial and current status of this family with specific reference to the services offered or performed in these categories.

Family Name _____ Family I.D. _____

Date of Termination _____

Family Members (full names)

Mother _____

Father (or step-father) _____

Target Child _____

Other Children _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Other Adults (include relation to family)

NAME	RELATION TO FAMILY
_____	_____
_____	_____
_____	_____
_____	_____

Primary Cause of Termination:

Children successfully placed with natural family _____

Children no longer at risk of placement _____

Children in other permanent placement _____

Family discontinued services _____

Family refused services offered _____

Primary caretaker hospitalized _____

Family moved out of target area _____

Incarceration occurred _____ To whom _____

APPENDIX P (continued)

Death occurred _____ To whom _____

Staff decision - due to substance abuse _____
- due to psychological instability _____
- due to long-term physical health problem _____

Foster Care Involvement:

A. Are the same children still in foster care placement? _____ YES _____ NO

If yes, state children's names and ages:

NAME	AGE

Has there been court activity concerning this (these) placement(s)? _____ YES _____ NO

If yes, did the court determine that:

The children remain in the private foster care facility for an additional six months _____

The children remain/be placed in an institutional setting for six months/one year _____

The children be considered for permanent placement _____

B. Have any children previously in placement been returned home during this service? _____ YES _____ NO

If yes, state children's names and ages:

NAME	AGE

APPENDIX P (continued)

(Beside each description below, write the appropriate child's name)

Adjustment to or in the natural home has been:

Smooth, with problems _____

Average, with some problems _____

Poor, with a lot of problems _____

Terrible, with overwhelming problems _____

Child is returning to placement _____

C. Have any children previously at home been placed during this service? _____ YES _____ NO
If yes, state children's names and ages:

NAME	AGE	REASONS FOR PLACEMENT

State the recommendations of PACT for the future placement of this family's children:

That they remain with their natural family _____

That they ultimately be returned to their natural family _____

That they be temporarily placed into short-term foster care _____

That they be placed into long-term foster care _____

That they be placed into a guardianship situation _____

That they be placed into a long-term institutional setting _____

That they be permanently placed into adoption _____

APPENDIX P (continued)

INITIAL/CURRENT STATUS // SERVICES OFFERED/PERFORMED

(The following six areas were/are six primary goals of this project. Summarize how they've been met.)

1. The ability to organize and maintain home environment for the growth and development of the child(ren):

In this area, this family, when compared to other families you've worked with in this project, would be rated as:

Better than ____ Equal to ____ Almost as good ____ Poor ____ Terrible _____

If this problem has remained the same during intervention, was this due to:

Family's lack of motivation _____
Bureaucratic red tape _____
Friction between client and PACT Counselor _____
Lack of sufficient time with family _____
Insurmountable nature of problem _____
Limitations of project's services _____
Other _____

2. Knowledge and skill in low income budgeting:

APPENDIX P (continued)

In this area, this family, when compared to other families you've worked with in this project, would be rated as:

Better than ____ Equal to ____ Almost as good ____ Poor ____ Terrible ____

If this problem has remained the same during intervention, was this due to:

Family's lack of motivation _____
Bureaucratic red tape _____
Friction between client and PACT Counselor _____
Lack of sufficient time with family _____
Insurmountable nature of problem _____
Limitations of project's services _____
Other _____

3. Child Care Skills - a. Sensitivity to child's changing needs

In this area, this family, when compared to other families you've worked with in this project, would be rated as:

Better than ____ Equal to ____ Almost as good ____ Poor ____ Terrible ____

If this problem has remained the same during intervention, was this due to:

Family's lack of motivation _____
Bureaucratic red tape _____
Friction between client and PACT Counselor _____
Lack of sufficient time with family _____
Insurmountable nature of problem _____
Limitations of project's services _____
Other _____

3. Child Care Skills - b. Utilization of Socially Acceptable Management Techniques:

APPENDIX P (continued)

In this area, this family, when compared to other families you've worked with in this project, would be rated as:

Better than ____ Equal to ____ Almost as good ____ Poor ____ Terrible ____

If this problem has remained the same during intervention, was this due to:

Family's lack of motivation _____
Bureaucratic red tape _____
Friction between client and PACT Counselor _____
Lack of sufficient time with family _____
Insurmountable nature of problem _____
Limitations of project's services _____
Other _____

3. Child Care Skills - c. Adequate and appropriate disciplinary control of children:

In this area, this family, when compared to other families you've worked with in this project, would be rated as:

Better than ____ Equal to ____ Almost as good ____ Poor ____ Terrible ____

If this problem has remained the same during intervention, was this due to:

Family's lack of motivation _____
Bureaucratic red tape _____
Friction between client and PACT Counselor _____
Lack of sufficient time with family _____
Insurmountable nature of problem _____
Limitations of project's services _____
Other _____

4. Nutrition - a. Health Standards of Family

In this area, this family, when compared to other families you've worked with in this project, would be rated as:

Better than ____ Equal to ____ Almost as good ____ Poor ____ Terrible ____

If this problem has remained the same during intervention, was this due to:

Family's lack of motivation _____
Bureaucratic red tape _____
Friction between client and PACT Counselor _____
Lack of sufficient amount of time with family _____
Insurmountable nature of problem _____
Limitations of project's services _____
Other _____

4. Nutrition - b. Medical Care - Use of community health resources

In this area, this family, when compared to other families you've worked with in this project, would be rated as:

Better than ____ Equal to ____ Almost as good ____ Poor ____ Terrible ____

If this problem has remained the same during intervention, was this due to:

Family's lack of motivation _____
Bureaucratic red tape _____
Friction between client and PACT Counselor _____
Lack of sufficient amount of time with family _____
Insurmountable nature of problem _____
Limitations of project's services _____
Other _____

5. Awareness and use of community resources (non-medical, e.g. social services, community programs, church organizations, etc.)

APPENDIX P (continued)

In this area, this family, when compared to other families you've worked with in this project, would be rated as:

Better than ____ Equal to ____ Almost as good ____ Poor ____ Terrible ____

If this problem has remained the same during intervention, was this due to:

Family's lack of motivation _____
Bureaucratic red tape _____
Friction between client and PACT Counselor _____
Lack of sufficient amount of time with family _____
Insurmountable nature of problem _____
Limitations of project's services _____
Other _____

6. Physical environment (e.g. safety, cleanliness, organization, etc.)

In this area, this family, when compared to other families you've worked with in this project, would be rated as:

Better than ____ Equal to ____ Almost as good ____ Poor ____ Terrible ____

If this problem has remained the same during intervention, was this due to:

Family's lack of motivation _____
Bureaucratic red tape _____
Friction between client and PACT Counselor _____
Lack of sufficient amount of time with family _____
Insurmountable nature of problem _____
Limitations of project's services _____
Other _____ _____

---

1. What bonus, positive effects occurred which were a spinoff of you and your team's intervention:

NAME OF FAMILY MEMBER	BONUS EFFECT
_____	_____
_____	_____

APPENDIX P (continued)

_____	_____
_____	_____
_____	_____
_____	_____

2. What overall effect do you feel that your team's intervention had on the well-being and functioning of this family?

Negative effect ____ No effect ____ Slightly positive effect ____

Moderately positive effect ____ Very positive effect ____

References

Bachman, J.G., Kahn, R.L., Mednick, M.T., Davidson, T.N., and Johnson, L.D. *Youth and transition* (Vol. 1): *Blueprint for a longitudinal study of adolescent boys*. Ann Arbor: Institute for Social Research, 1969.

Baumrind, D. Current patterns of parental authority. *Developmental Psychology Monographs*, 1971, *4*, (1,2).

Bowlby, J. *Attachment and loss* (Vol. 1). New York: Basic Books, Inc., 1969.

Bryce, M.E., and Ehlert, R.C. 144 foster children. *Child Welfare*, 1971, L (9), 499–503.

Caldwell, B.M., Heider, J., and Kaplan, B. The inventory of home stimulation. Unpublished manuscript, 1968. Syracuse University.

Caldwell, B.M., Wight, C.M., Honig, A.S., and Tannenbaum, J. Infant daycare and attachment. *American Journal of Orthopsychiatry*, 1970, *40*, 397–412.

Chilman, C.S. Programs for disadvantaged parents. In B.M. Caldwell and H.N. Ricciuti (Eds.), *Review of child development research* (Vol. 3). Chicago: University of Chicago Press, 1973.

Cochran, M.M. A comparison of group day and family child-rearing patterns in Sweden. *Child Development*, 1977, *48* (2), 702–707.

Elmer, E. Child abuse: A symptom of family crises. In E. Pavenstedt, M.D., and V.W. Bernard, M.D., (Eds.), *Crises of family disorganization*. (U.S. Public Health Service, *NIMH, MH* 14739). New York: Behavioral Publications, 1971, 51–58.

Elmer, E., and Gregg, G.S. Developmental characteristics of abused children. *Pediatrics*, 1967, *40*, 596–602.

Emlen, A. (Ed.) *Barriers to planning for children in fostercare*. Portland, Oregon: Portland State University, Regional Research Institute for Human Services, 1976.

Fanshel, D. The exit of children from fostercare: An interim research report. *Child Welfare*, 1971, *L* (2), 65–81.

Fanshel, D. Status changes of children in fostercare: Final results of the Columbia University longitudinal study. *Child Welfare*, 1976, *LV* (3), 143–171.

Fanshel, D., and Shinn, E.B. *Dollars and sense in the foster care of children*. New York: Child Welfare League of America, 1972.

Fraiberg, S. *Every child's birthright: In defense of mothering*. New York: Basic Books, Inc., 1977.

Garbarino, J. The human ecology of child maltreatment: A conceptual model for research. *Journal of Marriage and the Family*, 1977, *39*, (4), 721–735.

Giblin, P.T., Starr, R.H., Jr., and Agronow, S.J. *Responsivity and child abuse*. Manuscript submitted for publication, 1978.

Gil, D. Unravelling child abuse. *American Journal of Orthopsychiatry*, 1975, *45*, 601–618.

Gruber, A.R. *Children in fostercare, destitute, neglected, . . . betrayed*. New York: Human Services Press, 1978.

Gurin, P., Gurin, G., Lao, R.C., and Beattie, M. Internal-external control in the motivational dynamics of negro youths. *Journal of Social Issues*, 1969, *25*, 29–53.

Himelrick, J.B. (Ed.). *Comprehensive services to young children and their families, an interagency approach*. Charleston, WV: Office of the Governor, 1976.

Jenkins, S. Duration of fostercare: Some relevant antecedent variables. *Child Welfare*, 1967, *46*, 454.

Jenkins, S., and Norman, E. *Beyond placement: Mothers view of fostercare*. New York: Columbia University Press, 1975.

Jones, M.A., Neuman, R., and Shyne, A.W. *A second chance for families: Evaluation of a program to reduce fostercare*. New York: Child Welfare League of America, 1976.

Kagan, J., Kearsley, R., and Zelazo, P. *Infancy: Its place in human development*. Cambridge: Harvard University Press, 1978.

Keister, M.E. *Final report*. Greensboro, NC: North Carolina Training Center for Infant-Toddler Care, 1970.

Lash, T.W., Sigal, H., et al. *State of the child: New York City*. New York: Foundation for Child Development, 1976.

Light, R.J. Abused and neglected children in America: A study of alternative policies. *Harvard Educational Review*, 1973, *43* (4), 556–598.

Murphy, G.L., Murphy, L.B., and Newcomb, T.M. *Experimental social psychology*. New York: Harper, 1937.

National Research Council Advisory Committee on Child Development. *Toward a national policy for children and families*. Washington, D.C.: National Academy of Sciences, 1976.

Pavenstedt, E., M.D. (Ed.). *The drifters, children of disorganized lowerclass families*. Boston: Little, Brown, 1967.

Pavenstedt, E., M.D., and Bernard, V.W., M.D. (Eds.) *Crises of family disorganization.* New York: Behavioral Publications, 1971.

Pike, V., et al. *Permanent planning for children in fostercare: A handbook for social workers.* (U.S. Department of Health Education, and Welfare, Children's Bureau, DHEW Publication No. [OHDS] 77-30124). Portland, Oregon: Regional Research Institute for Human Services, Portland State University, 1977.

Podell, L. Family planning by mothers on welfare. *Bulletin New York Academy of Medicine,* 1973, *49,* 931–937.

Polansky, N.A. (Ed.). *Social work research.* Chicago: The University of Chicago Press. 1975, 14–15.

Polansky, N.A., Hally, C., and Polansky, N.F. *Profile of neglect; A survey of the state of knowledge of child neglect.* Mimeographed report prepared for Community Services Administration, Washington, D.C. 1975. (NITS No. SHR 0000848). Available from Georgia University, School of Social Work, Athens, Georgia.

Relich, R., Giblin, P.T., Starr, R.H., Jr., and Agronow, S.J. *Motoric behavior in abused and non abused children: Observations of parent-child interactions.* Manuscript submitted for publication, 1978.

Russell, R. (Ed.). *The needs of children in Michigan.* [Michigan] State Child Care Study Committee, 1976.

Sellitz, C., Wrightsman, L.S., and Cook, S.W. *Research methods in social relations,* (3rd ed.). New York: Holt, Rinehart, and Winston, 1976.

Shapiro, D. *Agencies and foster children.* New York: Columbia University Press, 1976.

Sherman, E.A., Neuman, R., and Shyne, A.W. *Children adrift in fostercare: A study of alternative approaches.* New York: Child Welfare League of America, 1974.

Shyne, A.W. Evaluation in child welfare. *Child Welfare,* 1976, *LV* (1), 5–18.

Shyne, A.W., Sherman, E.A., and Phillips, M.H. Filling a gap in child welfare research: Service for children in their own homes. *Child Welfare,* 1972, *LI* (9), 562–573.

Spinetta, J.J., and Rigler, D. The child-abusing parent: a psychological view. *Psychological Bulletin,* 1972, *77,* 296–304.

Starr, R.H., Jr. The controlled study of the ecology of child abuse and drug abuse. *The International Journal of Child Abuse and Neglect.* In press, 1979.

State Child Care Study Committee. *The needs of children in Michigan: Report and recommendations.* [Lansing] Michigan, 1976.

Stein, T.J., and Gambrill, E.D. *Decision making in fostercare.* Berkeley, Calif.: University of Chicago Extension Publications, 1976.

Wagner, M., and Wagner, M. *The Danish national child-care system.* Boulder, Colo.: Westview Press, 1976.

Weissman, H.H. *Integrating services for troubled families.* Washington, D.C.: Jossey-Bass, 1978.

Wiltse, K.T., and Gambrill, E. Foster care, 1973: A reappraisal. *Public Welfare,* 1974, *32,* 7–15.

PACT: Parents and Children Together

In recent years, it has become clear that many interdependent factors influence parental treatment of children. The family is not an island, but part of a total dynamic process involving the personal history and behaviors of each member, the social milieu, and interactions among themselves and with the social environment. In cases of abuse and neglect, parts of these interactional patterns have gone awry. New ways of thinking and relating must be learned if families are to remain intact. PACT is one response to this need.

PACT—Parents and Children Together—is a highly appropriate acronym for the program for which it stands. It is a project which provides intensive, home-based intervention service to low-income families who have or are at risk of having a child placed in foster care due to inadequate parenting or an unwholesome home environment. PACT home counselors try to bring about positive changes in the child-rearing practices and home management skills of parents so that the child(ren) may safely remain with or be returned to the natural parent(s). That is, the project's basic goal is to keep *parents and children together*.

This report describes PACT's philosophy and operation in sufficient depth and detail so that it can serve as a model for others who are seeking an "alternative to foster care."

Department of Family and Consumer Resources
Wayne State University, Detroit, Michigan 48202

L.C. 79-15980